ITS-SIDS Alternative Sleep Position/Use of Wedge Health Care Professional Waiver

This must be completed by a physician, nurse practitioner, or physician's assistant – 10A NCAC 09.0606/ 10A NCAC 09.1724(e)

This form must be used for an infant aged six months or less. This form may be used for an infant older than six months.

Parent/guardian completes this section.

Child's name _____ Date of birth _____ Age in months _____

Parent/guardian name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

Child's primary health care professional completes this section.

Health care professional's name _____

Name of practice _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell or Pager _____ Fax number _____

Email _____

N.C. Child Care Law requires that child care facilities place all infants on their backs to sleep. At the advice of the infant's primary health care professional, the parent/guardian may authorize the facility to place their infant in an alternative sleep position or to use a wedge for medical reasons. The center shall retain the waiver in the child's record as long as the child is enrolled at the center.

Medical reason for alternative sleep position or use of wedge for infant named above _____

The recommended sleep position for this infant is _____

Specific placement and directions for use of wedge:_____

Effective Dates of Waiver: from _____/_____/_____ to _____/_____/_____

Health Care Professional's Signature _____ Date _____

Parent/guardian signs this statement.

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position/use a wedge as described above at the recommendation of my child's primary health care professional.

Parent/guardian signature _____ Date _____

An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility _____ID #_____

Facility Representative's Signature _____ Date _____

North Carolina Child Care Health and Safety Resource Center
800.367.2229
healthychildcare.unc.edu