Reset Form

SAFE SLEEP MEDICAL WAIVER FORM

State Form 56619 (R1 / 01-25)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

All information must be completed. Forms with blanks may be returned. The approved original must be placed in the infant's file.

It is a requirement in Indiana to follow the American Academy of Pediatrics (AAP) recommendations regarding infant sleep in regulated child care programs. Infants under twelve (12) months of age must be placed **alone**, on their **back to sleep**, in a **crib or porta-crib**. Pacifiers are allowed in the sleep environment.

At the written order of the infant's personal health care provider with independent prescriptive authority, a signed Child Care Medical Waiver with clear alternate directions must be on file for infants requiring alternate positions or accommodations. The medical reason for deviation from AAP recommendations must be clearly stated below. This waiver request must be approved by the Office of Early Childhood and Out of School Learning prior to implementation.

Name of program	County
Name of infant	Date of birth of infant *(month, day, year)*
Name of parent or guardian	
Name of Health Care Provider or Specialist *(print)*	
Address of Health Care Provider or Specialist *(number and street, city, state, and ZIP code)*	

Telephone number ( )	Fax number *(optional)* ( )	E-mail address

TO BE COMPLETED BY THE INFANT'S HEALTH CARE PROVIDER OR SPECIALIST

Describe the health or medical condition that requires an alternate sleep position. Include height, weight, developmental age and any diagnoses or equipment that support variation from the AAP recommendations. Reflux alone is not approvable.

Describe the alternate position or accommodation for the infant in group care.

Describe the equipment /device parent will provide to child care program, such as height or degree of wedge.

The above instructions are effective from the start date until the date noted, the accommodation is no longer necessary or the infant reaches twelve (12) months.	Start date *(month, day, year)*	End date *(month, day, year)*

I believe that the medical benefit of this alternate directive outweighs the risk for SIDS or positional asphyxia.

Signature of medical provider	Date *(month, day, year)*

As the parent or guardian of the above named infant, I acknowledge the risks for SIDS and positional asphyxia associated with altering an infant's position or sleep environment from the AAP recommendations. I authorize this facility / program to follow the medical advice as outlined by my infant's Medical provider. I will provide any device or equipment necessary.

Signature of parent / guardian	Date *(month, day, year)*

FOR OFFICE USE ONLY

Date received *(month, day, year)*	Signature of child care manager ☐ Yes ☐ No	Date approved *(month, day, year)*
License / registration number of program		