Child Care Facility_____

WAIVER STATEMENT ON INFANT SLEEP POSITION

Dear Physician,

At our facility _____, all infants will be placed on their backs to sleep.
name of facility

Our facility is required to have a written note by a physician that states a child may sleep in a position other than on the back. Please complete and sign the following waiver if it is medically necessary for this child to sleep in an alternative position.

Thank you,

_____
staff title/name

INFANT SLEEP POSITION WAIVER

It is in the best interest of this child, _____, to sleep
name of child

on his/her _____ instead of the back.
sleep position

Signature: _____ Date: _____
physician

Please describe sleep position and how to accommodate the position. _____

_____

_____

_____

_____

_____

_____

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