

Physician Permission for Infant Alternate Sleep Position

In order to reduce the risk of Sudden Unexpected Infant Death, including Sudden Infant Death Syndrome, suffocation and other sleep related deaths, Colorado Rules and Regulations for both Family Child Care Homes and Child Care Centers follow the recommendation from the American Academy of Pediatrics, which prohibits child care providers from placing infants under the age of 1 year, in a sleep position other than on the back, in an approved crib.

Name of Child Care Facility _____ License # _____

Parent Permission:	
Child Name _____	Date of Birth ____/____/____
<u>Alternate Sleep Position:</u> Colorado Rules and Regulations for Family Child Care Homes and Child Care Centers requires all infants less than 1 year of age be placed on their back for sleep unless there is a special health condition that requires that an infant use an alternate sleep position.	
I, _____ give consent for my child to sleep in an alternate sleep position as indicated by my child's physician. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider.	
_____ Parent or Legal Guardian Signature	____/____/____ Date

Physician Permission:	
I understand that back sleeping is required for all infants by Rules Regulating Family Child Care Homes and Child Care Centers and is the safest sleep position for infants. I direct an alternative position for this infant for the medical reason(s) stated below. By signing this form I am acknowledging that I am directing only an alternative sleep position and that the infant must always be placed in an approved crib for sleep.	
The infant named above has the following medical reason(s) which necessitates an alternate sleep position: _____ (attach additional information if necessary)	
The appropriate sleep position for the infant is: ___ Sleeping on Stomach ___ Sleeping on Side	
Effective dates of Permission: From: ____/____/____ to ____/____/____	
Date infant will be re-evaluated for the need for alternate sleep position: ____/____/____	
_____ Physician Signature	____/____/____ Date
<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;">Office Stamp, or write Name, Address and Phone Number</div>	