Medical Waiver
For Alternate Sleeping Practice or Position

All information must be completed

It is Indiana's policy to follow American Academy of Pediatrics (AAP) recommendations regarding infant sleep in regulated child care programs. Infants under 12 months of age are always placed on their backs to sleep, in a crib or porta-crib (may use play yard in homes), without a blanket or any items with the exception of a pacifier in their sleep environment.

At the order of the infant's personal health care provider with prescriptive authority, a signed medical waiver with clear alternate directions will be on file for infants requiring alternate positions or accommodations that state the medical reason as to why the infant's position or the sleep environment deviates from AAP recommendations. In that case, a waiver notice will be posted in a conspicuous location on or at the infant's crib that does not block the infant from the caregivers view. The notice will only state the position in which the infant should sleep, the date the waiver was signed and the expiration date. The actual medical waiver should be placed in the infant's file since it contains confidential medical information.

Name of infant	Name of parent or guardian	Infant's birthdate
Name of Health Care Provider or Specialist		
Address of Health Care Provider or Specialist		
Address of Practice		
Phone	Fax(optional)	E-mail

TO BE COMPLETED BY INFANT'S HEALTH CARE PROVIDER or SPECIALIST

The above named infant has the following health or medical condition that requires an alternate sleep position:		
Describe the alternate position or accommodation using a medical device for the infant:		
Additional instructions or equipment /device parent will provide to child care program:		
The above instructions are effective from (fill in boxes to the right)	Date to	Date

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

Physician signature _____ ***Date*** _____

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. I authorize this facility/program to follow the medical advice as outlined by my infant's Health Care Provider. I will provide the medical device necessary.

Parent/Guardian signature _____ **Date** _____