Indiana
Safe Sleep Program
Safe Sleep Form
MOTHER'S DEMOGRAPHIC INFORMATION (Required)

CHECK HERE IF MOTHER IS NOT THE PRIMARY CAREGIVER:

MOTHER'S MEDICAID#: _____ **PRIVATE INSURANCE:**

MOTHER'S DATE OF BIRTH: __/___/____

FIRST NAME: _____ **LAST NAME:** _____ **MAIDEN NAME:** _____

DO YOU HAVE OTHER CHILDREN?: ___Yes ___No **If yes, how many?:** _____

PLEASE CHECK HERE IF THE MOTHER HAS USED A DIFFERENT NAME **OTHER FIRST NAME:** _____

OTHER LAST NAME: _____

RACE/ETHNICITY *(Please check all that apply)*: __Asian __ Black or African American __White __Chinese __ Japanese __ Filipino __ Guamanian __ Korean __ Samoan __ Vietnamese __ Hispanic __ Burmese __ Other/Multiracial __ Unknown

PRIMARY PHONE NUMBER: (_____)_____-_____ **PHONE TYPE:** __ Home phone ___ Cell phone

SECONDARY PHONE NUMBER: (_____)_____-_____ **PHONE TYPE:** __ Home phone ___ Cell phone

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **COUNTY OF RESIDENCE:** _____

MOTHER'S EDUCATION LEVEL: __ 8th grade or less __ Some high school __ GED Certificate ___ High school graduate ___ __ Some college __ 2-Year Community college graduate __ 4-year college graduate __ Graduate School

FATHER'S DEMOGRAPHIC INFORMATION

CHECK HERE IF FATHER IS NOT THE PRIMARY CAREGIVER: *(If no, skip to Primary Caregiver Information)*

CHECK HERE IF SAME RESIDENCE AS ABOVE

FATHER'S MEDICAID#: _____ **PRIVATE INSURANCE:**

FATHER'S DATE OF BIRTH: __/___/____

FIRST NAME: _____**LAST NAME:** _____

DO YOU HAVE OTHER CHILDREN?: ___Yes ___No **If yes, how many?** _____

PLEASE CHECK HERE IF THE FATHER HAS USED A DIFFERENT NAME **OTHER FIRST NAME:** _____

OTHER LAST NAME: _____

RACE/ETHNICITY *(Please check all that apply)*: __Asian __ Black or African American __White __Chinese __ Japanese __ Filipino __ Guamanian __ Korean __ Samoan __ Vietnamese __ Hispanic __ Burmese __ Other/Multiracial __ Unknown

PRIMARY PHONE NUMBER: (_____)_____-_____ **PHONE TYPE:** __ Home phone ___ Cell phone

SECONDARY PHONE NUMBER: (_____)_____-_____ **PHONE TYPE:** __ Home phone ___ Cell phone

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **COUNTY OF RESIDENCE:** _____

FATHER'S EDUCATION LEVEL __ 8th grade or less __ Some high school __ GED Certificate ___ High school graduate ___ __ Some college __ 2-Year Community college graduate __ 4-year college graduate __ Graduate School

PRIMARY CAREGIVER'S DEMOGRAPHIC INFORMATION

PLEASE IDENTIFY THE PRIMARY CAREGIVER RELATIONSHIP TO THE CHILD: *(If not the mother or father):*

__ Grandparents __ Aunt __ Uncle __ Other **IF OTHER, PLEASE SPECIFY:** _____

FIRST NAME OF PRIMARY CAREGIVER: _____**LAST NAME:**_____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____**ZIP CODE:** _____ **COUNTY OF RESIDENCE:** _____

CHILD'S INFORMATION

CHECK HERE IF BABY HAS NOT BEEN BORN:

IF BABY HAS NOT BEEN BORN, PLEASE ENTER THE DUE DATE: __/___/_____

FIRST NAME: _____ **LAST NAME:** _____ **MIDDLE NAME:** _____

DATE OF BIRTH: __/___/_____

BABY'S SEX: __ Male __ Female

BIRTH PLURALITY: __ Single __ Twins __ Triplets **BIRTH ORDER:** __ 1 __ 2 __ 3

ADDITIONAL CHILD INFORMATION FOR PLURAL BIRTH (Twins/triplets/etc.)

CHECK HERE IF BABY HAS NOT BEEN BORN:

IF BABY HAS NOT BEEN BORN, PLEASE ENTER THE DUE DATE: __/___/_____

FIRST NAME: _____ **LAST NAME:** _____ **MIDDLE NAME:** _____

DATE OF BIRTH: __/___/_____

BABY'S SEX: __ Male __ Female

BIRTH PLURALITY: __ Single __ Twins __ Triplets **BIRTH ORDER:** __ 1 __ 2 __ 3

CHECK HERE FOR 3 OR MORE CHILDREN

IF 3 OR MORE CHILDREN, PLEASE PROVIDE THEIR DEMOGRAPHIC INFORMATION AS ABOVE: _____

_____

OTHER INFORMATION

DID YOU SMOKE DURING THE PREGNANCY? : __ Yes __ No

DO MEMBERS OF YOUR HOUSEHOLD SMOKE? : __ Yes __ No

IF YES, DO THEY SMOKE INSIDE THE HOUSE?:

HOW MANY PEOPLE SMOKE IN YOUR HOUSEHOLD?: ____

DO YOU SMOKE NOW, OR WILL YOU AFTER PREGNANCY?: __ Yes __ No __ _

DOES THE MOTHER TELL CAREGIVERS HOW TO PLACE THE BABY TO SLEEP? : __ Yes __ No

PLEASE IDENTIFY THE FEEDING TYPE FOR YOUR BABY: *(Check all that apply)* __ Bottle feeding __ Breast feeding __ Both __ N/A

DOES THE BABY USE A PACIFIER?: *(Check all that apply)* __ Yes __ No __ N/A

CURRENT SLEEP LOCATION?: *(Check all that apply)* __ Adult bed __ Baby crib __ Car seat __ Sofa/chair __ Other

CURRENT SLEEP POSITION?: *(Check all that apply)* ___Stomach ___Back ___Side

DOES CAREGIVER RECEIVE?: *(Check all that apply)* ___WIC ___CHIP ___Food Stamps ___Medicaid

DAYCARE TYPE?: *(Check all that apply)* ___Childcare ___Home-based ___Daycare Center ___Relative/Friends ___ None

CRIB DISTRIBUTION (To be filled out by DISTRIBUTION SITE ONLY)

HOW MANY CRIBS DID YOUR CLIENT RECEIVE TODAY?: ___1 ___2 ___3 ___4

WAS HOLD HARMLESS AGREEMENT SIGNED?: ___Yes ___No

WAS A SAFE SLEEP KIT DISTRIBUTED WITH OR WITHOUT A CRIB?: ___With crib ___Without crib

DATE SAFE SLEEP KIT DISTRIBUTED: ____/____/_____

IF THE SAFE SLEEP KIT WAS DISTRIBUTED TO THE CAREGIVER, PLEASE IDENTIFY THE LOCATION: (Including Indiana County and Site Name): _____

WAS SAFE SLEEP EDUCATION PROVIDED TO THE CAREGIVER?: __Yes __ No

DATE SAFE SLEEP EDUCATION PROVIDED: ____/____/_____

IF YES, WHO PROVIDED THE EDUCATION?: _____

SUBMITTED BY:

FIRST NAME: _____ LAST NAME: _____

PHONE NUMBER: _____

SITE NAME : _____

COMMENTS: