

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:

Cribs for Kids®

HOLD HARMLESS AGREEMENT

In exchange for the grant of a **Graco® Pack n' Play®** portable baby crib, receipt of which is hereby acknowledged, I _____, agree to indemnify, defend and hold harmless the Cribs for Kids® program, as well as officers, agents and employees of the above from all claims or losses accruing or resulting to any person, firm or corporation who claim to be injured or damaged as a result of acts or omissions involving the placement and/or use of the portable cribs provided within this Cribs for Kids® program.

Signed _____

Date _____

Witness _____

Date _____