Infant Health Care Plan

Child's Name: ____ Date of Birth: _______________

Parent/Guardian Name(s): ____

Home Phone: __________________________________ Work Phone: ___________________________

Parent/Guardian Permission

I ask that school/childcare staff provide the following care to my child, according to the Health Care Provider's signed instructions on the bottom portion of this form. By signing this document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with program staff.

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless Orchard Valley Learning Center, its officers, directors, and employees, from all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that I have been provided with information concerning SIDS. I further authorize Orchard Valley Learning Center and its employees to use practices that are not standard, at the recommendation of my child's health care provider, as described below.

Parent/Guardian Signature:____

Health Care Provider Authorization

Please check all that apply to the above mentioned infant:

☐ Swaddling Notes: ____

☐ Elevated Crib Notes: ____

☐ Alternate sleep position to back Notes: ____

Orchard Valley places all infants on their backs to sleep. At the advice of the infant's physician, the center may be authorized to use an alternative sleep position for the infant for medical reasons.

The above named child has the following medical condition that necessitates an alternative sleep position:

____

☐ Swing/Car Seats Sleep Notes: ____

☐ Food Thickener Notes: ____

Comments/Instructions: ____

____

Start Date: ________________________________ End Date: ___________________________________

Health Care Provider Signature: _____________________________________ Date: ___________________

Name of Practice: ____ Phone: _____________________