DEPARTMENT OF HUMAN SERVICES

DHS-7776-ENG 9-19

Family Child Care Admission and Arrangements

PLEASE PRINT. Complete one form for each child in care. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Rules 9502.0405, subpart 4, the provider shall obtain the required information for each child prior to admission and keep the information up to date.

CHILD INFORMATION

Last Name	First Name	Birthdate (mm/dd/yyyy)	Date Enrolled in Care

Address	City	State	Zip Code

PARENT OR GUARDIAN # 1

Last Name	First Name	Place of Employment and Work Phone No.

Address of Employer	City	State	Zip Code

Email	Home Phone	Cell Phone

Address (if different from child)	City	State	Zip Code

PARENT OR GUARDIAN # 2

Last Name	First Name	Place of Employment and Work Phone No.

Address of Employer	City	State	Zip Code

Email	Home Phone	Cell Phone

Address (if different from child)	City	State	Zip Code

EMERGENCY CONTACT FOR CHILD IF PARENTS CAN'T BE REACHED One Contact Required

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

Last Name	First Name	Relationship and Phone Number

Address	City	State	By checking I am authorizing this person to pick up my child ☐

EMERGENCY INFORMATION FOR CHILD

Hospital to be used for emergencies	Physician's Name	Telephone

Address	City	State	Zip Code

Dentist to be used for emergencies	Dentist's Name	Telephone	If you don't have a dentist yet for your child, check this box ☐

Address	City	State	Zip Code

CHILD CARE PROVIDER

Name	License #
Tiffany R Tupy	1104170

Address	City	State	Zip Code
806 1st Ave S.E	New Prague	MN	56071

ARRANGEMENTS

Financial Arrangements

See Financial Agreement

Services Provided (Including Days, Hours, Meals, Etc.)

See Financial Agreement

Special Conditions (Special Diet, Special Needs)

Does Your Child Have Allergies YES ☐ NO ☐ NOTE: If Yes, Complete the Allergy Information Form

LIABILITY INSURANCE NOTIFICATION

Pursuant to 245A.152(a) A license holder must provide a written notice to all parents or guardians of all children to be accepted for care prior to admission stating whether the license holder has liability insurance. This notice may be incorporated into and provided on the admission form used by the license holder. Select one of the options below.

☑ I do have liability insurance. A current certificate of coverage of insurance is available for inspection to all parents and guardians of children receiving services and to all parents seeking services from the family child care program. The expiration date is: ☐

☐ I do not have liability insurance

PERMISSIONS

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO PROVIDE TRANSPORTATION FOR MY CHILD
Yes ☐ No ☐

ANY SPECIAL TRAVEL ARRANGEMENTS

I have received a copy of the maltreatment of minors mandated reporter policy ☑

AUTHORIZATION IS HEREBY GIVEN TO THE CHILD CARE PROVIDER AS NAMED IN THE ITEM ABOVE, TO OBTAIN EMERGENCY MEDICAL CARE OR TREATMENT IN THE EVENT OF AN EMERGENCY Yes ☐ No ☐

AUTHORIZATION: We the undersigner hereby agree to abide by the arangements and authorizations so stated above. We have discussed the information required in the rule part 9502.0405

Signature of Child Care Provider	Date
Signature of Parent / Guardian	Date
Signature of Parent / Guardian	Date

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7736-ENG 7-17

Family Child Care Allergy Information Form

PLEASE PRINT: Complete one form for each child. This form must be kept on file at the family child care home. Please Note: Pursuant to MN Statute 245A.51, subd. 1, before admitting a child for care, the license holder must obtain information about any known allergy from the child's parent or legal guardian. The child allergy information must be documented on a form approved by the commissioner, readily available to all caregivers, and reviewed annually by the license holder and each caregiver.

CHILD INFORMATION

Last Name	First Name	Birthdate (mm/dd/yyyy)

PARENT OR GUARDIAN

Last Name	First Name	Phone No.

Physician's Name	Physician's Number

1. Please indicate items your child has an allergy to:

- ☐ Peanut / Peanut Products
- ☐ Fish / Shellfish
- ☐ Eggs
- ☐ Milk
- ☐ Soy Products
- ☐ Gluten
- ☐ Nuts
- ☐ Bee Stings
- ☐ Other (please indicate): _____

2. What things trigger an allergic reaction in your child?

3. What thing should be avoided due to the allergy?

4. What are the sign and symptoms of your child's allergic reaction? Be specific.

5. What treatment or medication does your child have in the event of an allergic reaction? (include doses):

6. What are the procedures for responding if your child has an allergic reaction?

Signature of Parent / Guardian	Date

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်ာ်. ဖဲနမ့ာ်လိဉ်ဘဉ်တာ်မၤစၢၤကလီလၢတာ်ကကျိးထံဝဲဒဉ်လံာ် တိလံာ်မိတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝိအပှၤမၤစၢၤတာ်လၢနဂီၢ်မ့တမ့ာ်ကိးဘဉ် 1-844-217-3549 တကွ်ာ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA4 (9-15)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, contact your county's ADA Coordinator

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name_____ Birthdate_____

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Prescription and non-prescription medication administration permission

Family Child Care

9502.0435 subp. 16 F (1) The provider shall obtain written permission from the child's parent prior to administering prescription and non-prescription medicines, diapering products, sunscreen lotions, and insect repellents. Nonprescription medicines, diapering products, sunscreen lotions, and insect repellents must be administered according to the manufacturer's instructions unless there are written instructions for their use provided by a licensed physician or dentist.

The provider shall obtain and follow written instructions from a licensed physician or dentist prior to administering each prescription medicine. Medicine with the child's name and current prescription information on the label constitutes instructions.

Product	Parent Signature APPROVES	Parent Signature DOES NOT APPROVE
Prescription and Non-Prescription Medicines		
Diapering Products		
Sunscreen Lotions		
Insect Repellents		

Additional information for provider:

_____

_____

DEPARTMENT OF HUMAN SERVICES

DHS-7773-ENG 8-22

OFFICE OF INSPECTOR GENERAL - LICENSING DIVISION

Family Child Care Travel and Activity Authorization

Permissions

◯ Yes ◯ No	I give permission for my/our child(ren) to leave the family child care home for travel in a car or on public transportation for any reason. I understand that the provider will always use proper safety restraints and will never leave any child unattended in a vehicle.
IF YES, LIST THE NAME(S) **AND** AGE(S) OF CHILD(REN):	
◯ Yes ◯ No	I give permission for my/our child(ren) to walk to and/or participate in activities geared for my child, but away from the child care home under the supervision of a provider or adult caregiver. My provider will inform me in advance of field trips beyond the immediate neighborhood. (park, library, local pool)
IF YES, LIST THE NAME(S) OF CHILD(REN):	
◯ Yes ◯ No	I give permission for my school age child(ren) to participate in (list activity below) outside the residence. I understand my child will not be under the supervision of the child care provider, substitute, or helper.
IF YES, LIST THE NAME(S) OF CHILD(REN) **AND** THE ACTIVITY:	

Signatures

Parent Signature

SIGNATURE	DATE

Provider Sigature

SIGNATURE	DATE

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Wading Pool Risks

Family Child Care

The use of wading pools in home child care settings could facilitate the transmission of infections among children and cause serious disease.

Guidelines for out-of-home child care programs have been jointly developed by the American Academy of Pediatrics and the American Public Health Association and published by the National Center for Education in Maternal and Child Health. These guidelines state that "small portable wading pools shall not be permitted" because they do not permit adequate control of sanitation and safety and provide a superior means of transmission of infectious diseases."

In Minnesota, we are particularly concerned about the potential for the enhanced transmission of *E. coli* O157:H7. This bacteria is passed in stool and is readily transmitted among children when contaminated hands or toys are placed in the mouth or contaminated food or water are consumed. Wading pools can easily become contaminated with stool.

Infection with *E. coli* O157:H7 is the primary cause of hemolytic uremic syndrome (HUS), the most common cause of kidney failure in children in this country. This syndrome usually involves prolonged hospital stays and is fatal in up to 5% of cases. The Minnesota Department of Health maintains information on infectious diseases.

Each year several *E. coli* O157:H7 outbreaks are identified in Minnesota in both child care homes and centers. These outbreaks often cause a disruption of parents' schedules and income for the child care provider because infected children need to be excluded from child care until they are no longer carrying the bacteria, which can take as long as 1-2 months. Several other disease causing agents, including *Giardia, Cryptosporidium,* and *Shigella* are also efficiently transmitted in wading pools. All of these agents can cause severe illness in children and are common in Minnesota. The Minnesota Department of Health maintains information reported to them about laboratory-confirmed infectious diseases. The transmission of these infections can occur even under the care of the most diligent and thoughtful child care providers as the infections can be spread even with mild symptoms.

Wading Pools Present the Risk of Drowning or Other Submersion Incidents.

The U.S. Consumer Product Safety Commission warns that young children can drown in small amounts of water, as little as two inches deep. Submersion incidents involving children usually happen in familiar surroundings and can happen quickly, even in the time it takes to answer the phone. In a comprehensive study of drowning and submersion incidents involving children under 5 years old, 77% of the victims had been missing from sight for 5 minutes or less. The Commission notes that toddlers in particular often do something unexpected because their capabilities change daily, and that child drowning is a silent death; there is no splashing to alert anyone that the child is in trouble.

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Wading Pool Permission Form

Family Child Care

Dear Parent or Legal Guardian:

The 2002 Minnesota Legislature passed a bill that allows portable wading pools to be used by family and group family child care providers when certain requirements are met. These requirements are specified in Minnesota Statutes, section 245A.14, subdivision 10.

A portable wading pool is defined as a pool with a maximum depth of 24 inches that is capable of being manually emptied and moved. These portable wading pools may only be used after:

1. The parent or legal guardian of the child has provided written consent to the license holder that specifies that the provider agrees to comply with all the requirements in Minnesota Statutes, section 245A.14, subdivision 10; and
2. The written consent includes a statement that the parent or legal guardian has received and read the document written by the Department of Human Services and the Department of Health titled: "Wading Pool Risks."

Please read the Wading Pool Risks form, and decide whether or not to permit your child(ren) to use a wading pool while under the care of your family child care provider.

If you have questions about the changes regarding wading pools, please contact your local public health department or the Minnesota Department of Health. If you have questions about child care licensing you should contact your local county Social Services Agency, or you may call the Minnesota Department of Human Services.

After completion, please give this form to your child care provider. Your child care provider will be monitored for compliance with these requirements, and this form will document your decision.

By signing this form, I am acknowledging that I have read the document written by the Department of Human Services and the Department of Health titled: "Wading Pool Risks." I have been given the opportunity to talk with my child care provider about the use of a wading pool, and I understand the risks associated with the use of a wading pool by my child(ren) while they receive child care services.

_____ I **do** consent to my child care provider's use of a wading pool with my child(ren).
_____ I **do not** consent to my child care provider's use of a wading pool with my child(ren).

_____
Name of Child(ren)

_____ _____
Parent Signature and Date Provider Signature and Date

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Swaddling Consent for an Infant

Placing a swaddled infant down to sleep in a licensed setting is *not* recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or legal guardian, a license holder may place the infant who has **not yet begun to roll over on their own** down to sleep in a crib, on their back, in a swaddle that is one-piece sleepwear that:

- does not have weighted materials, a hood or a bib;
- wraps over the infant's arms, fastens securely only across the upper torso, with no constriction of the hips or legs; and
- is not so tight that it restricts the infant's ability to breathe or so loose that the fabric could cover the infant's nose or mouth.

Any other type of swaddle, including with a blanket, is prohibited.

Prior to any use of swaddling for sleep, the license holder must obtain informed written consent for the use of swaddling from the parent or legal guardian of the infant.

I _____ , the parent/ legal guardian of _____ DOB _____
(Parent or legal guardian) (Infant) (Date of birth)

give written consent to _____ (Provider)

to place my infant to sleep in a crib, on their back, in a swaddle that meets the requirements above.

☐ I verify that my infant has NOT yet begun to roll over.

☐ I permit the provider to only use a swaddle that:

- does not have weighted materials, a hood or a bib;
- wraps over the infant's arms, fastens securely only across the upper torso, with no constriction of the hips or legs; and
- is not so tight that it restricts the infant's ability to breathe or so loose that the fabric could cover the infant's nose or mouth.

☐ I verify that I will immediately notify the provider when my infant has begun to roll over.

Parent or legal guardian signature _____ Date _____

Provider signature _____ Date _____

At the time that the parent, legal guardian, or provider observes that this infant has begun to roll over, this consent is no longer valid.

Infant has begun to roll over. Swaddling has been discontinued.

Date: _____ Provider initials: _____ Parent or legal guardian initials: _____

*Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Fourth Edition, 2019.

DEPARTMENT OF HUMAN SERVICES

Parent Cradleboard Request

This form is to document a parent or guardian's request to use a cradleboard for their infant in a licensed program.

Minnesota human services licensing requirements defines a cradleboard as a board or frame on which an infant is secured using blankets or other material, such as fabric or leather sides, and laces and often has a frame extending to protect the infant's head. The infant is always placed with the infant's head facing outward, and the infant remains supervised in the cradleboard while sleeping or being carried. (MN Statutes, 245A.02, subd. 5b)

Parent or guardian request

Child's name:_____ Child's birthdate:_____

Licensed program: _____

License number: _____

By signing this form, I request that the licensed program listed above use a cradleboard for my infant. The cradleboard may be used while my infant is sleeping or not sleeping. I understand that the program will only be able to use a cradleboard under the conditions of a variance approved by the Minnesota Department of Human Services that includes requirements for the safe use of a cradleboard. The license holder must check the cradleboard each month to ensure the cradleboard is structurally sound and there are no loose or protruding parts.

Parent or guardian's name (printed): _____

Parent or guardian's signature: _____ Date: _____

Monthly Cradleboard Check Form

(Use one form per cradleboard)

Child's name: _____

As required in 245A.146, subdivision 3, paragraph (f), if a cradleboard is used in a licensed setting, the license holder must check the cradleboard not less than monthly to ensure the cradleboard is structurally sound and there are no loose or protruding parts. The license holder shall maintain written documentation of this review. This is an optional form that may be used to document the monthly cradleboard checks.

Monthly cradleboard check	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Document date of check on this line (MM/DD/YEAR)												
Cradleboard check items	In the boxes below, place a plus (+) for meets requirements or a minus (-) for does not meet requirements for each item. Upon discovery of any issues during the check, document the action(s) taken below.											
The cradleboard is structurally sound (example, any ties or cloth are not worn down)												
The cradleboard has no loose or protruding parts												

Action taken regarding issues found during cradleboard check:

_____

_____

DEPARTMENT OF HUMAN SERVICES
LICENSING DIVISON

Directive for Alternative Infant Sleep Position

This form is the approved format to direct an alternative sleep position and must remain on file at the licensed location.

The American Academy of Pediatrics (AAP)* and the National Institute of Child Health and Human Development (NICHD) recommend back sleeping for babies to reduce the risk of sudden unexpected infant deaths (SUID) due to sudden infant death syndrome, suffocation, and other sleep related causes. The AAP further states that an alternative sleep position be considered only for the rare exception of infants for whom the risk of death when sleeping on the back is greater than the risk of SUID when sleeping on the stomach.

Sleeping babies are safest on their backs.

Minnesota law requires that licensed providers place infants to sleep in a crib, directly on a firm mattress. The provider must place the infant on his/her back for sleep unless the provider has a signed directive from a physician, an advanced practice registered nurse (APRN), or a physician assistant (PA) for an alternate sleep position for the infant. Car seats, swings, couches, the floor on a blanket, etc. are **not** acceptable as an alternative sleep position.

In addition, Minnesota law requires licensed providers to use a fitted crib sheet that fits tightly on the mattress and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. Nothing may be placed in the crib with the infant except the infant's pacifier, with nothing attached to the pacifier. These requirements apply to license holders serving infants up to one year of age. Licensed providers may only use cribs that meet requirements specified in statute and must inspect cribs monthly to assure they are safe.

** American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs. 4th ed. Itasca, IL: American Academy of Pediatrics; 2019*

I understand that back sleeping is recommended and is safest for babies. I am directing an alternative position for this infant for the medical reason(s) stated below. By signing this form, I acknowledge that I am directing only an alternative sleep position and that the infant must always be placed in an approved crib to sleep.

CHILD NAME	DATE OF BIRTH

☐ Place this infant on his/her STOMACH for sleep periods (***not recommended); OR***

☐ Place this infant on his/her SIDE for sleep periods (***not recommended)***

Diagnosed medical reason(s) for alternate sleep position:

_____

(Attach information if necessary)

Expected duration of need for alternate sleep position:

_____

List the date the infant will be re-evaluated for the need for an alternative sleep position by a physician, advanced practice registered nurse, or physician assistant:

_____

PRINTED NAME OF PHYSICIAN, APRN, OR PA	
PHYSICIAN, APRN, OR PA SIGNATURE	DATE

(Licensed providers must place an infant in a crib to sleep. Anything other than an approved crib is not acceptable as an alternative sleep position.)

Alternative Infant Sleep Position Parent Authorization

One of the easiest ways to lower a baby's risk of Sudden Unexpected Infant Death (SUID) due to sudden infant death syndrome (SIDS), suffocation, and other sleep related causes is to put the baby on the back to sleep for naps and at night. Health care providers used to think that babies should sleep on their stomachs, but research now shows that babies are less likely to die of SUID when they sleep on their backs. Since the recommendation to place a baby on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent. Placing babies on their back to sleep is the best way to reduce the risk of SUID.

The Safe Sleep for Your Baby resource provides the following recommendations:

1. Always place a baby on their back to sleep, for naps and at night. The back sleep position is the safest position for all babies and every sleep time counts.
2. A baby should sleep in a safety-approved crib on a firm mattress covered by a fitted sheet appropriate to the mattress size.
3. Keep soft objects, toys, loose bedding, pillows, blankets, quilts, sheepskins and crib bumpers out of the baby's sleep area. The only item that should be placed in the crib with the baby is a pacifier. If a pacifier is labeled, the label must be in good condition and securely adhered to the pacifier and nothing attached to the pacifier. **Please note: In licensed programs, the only item allowed in a crib with an infant is a pacifier with nothing attached to the pacifier.**

- As the parent providing this signed form I acknowledge that I have read the above information regarding the AAP and NICHD recommendations for sleeping babies safely, Minnesota's requirements for licensed providers, and recommendations from Safe Sleep for Your Baby.

  The Safe Sleep for Your Baby Brochure may be viewed at:
  https://www.nichd.nih.gov/sites/default/files/2023-01/STS_2022_Brochure_English.pdf
- As the parent providing this signed form, I acknowledge that I am aware that placing a baby on her/ his back for sleep has been recommended by health experts to be the safest way to place a baby for sleep.
- As the parent providing this signed form, I acknowledge that I am aware that since the recommendation to place babies on their back for sleep began, the SIDS rate in the United States has dropped by more than 50 percent.
- As the parent providing this signed form, I acknowledge that I am aware that placing a baby on the stomach or side, increases the baby's risk for dying from Sudden Unexpected Infant Death (SUID).
- As the parent providing this signed form, I acknowledge that I am aware that Minnesota Statutes, section 245A.1435, requires licensed providers to position an infant on the back for sleep unless the provider has a signed directive from a physician, APRN, or physician assistant for an alternate sleep position.

PARENT SIGNATURE	DATE
PROVIDER SIGNATURE	DATE

Note: The second and third pages of the Alternative Infant Sleep Position form must be signed by the appropriate people and remain on file.

Tiffs Tiny Tots

Licensed Family Child Care

EST. 2020

EMERGENCY CONTACTS
PERMISSION TO PICK UP

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____