Indiana
Safe Sleep Program
SAFE SLEEP FORM

MOTHER'S DEMOGRAPHIC INFORMATION

MOTHER'S RID NUMBER: ______________________ **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 AN ALIAS? ___ **OTHER 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:** __________________

CAREGIVER'S HIGHEST EDUCATION LEVEL ATTAINED __ 8th grade or below __ Some high school __ High school graduate

___ GED Certificate ___ 2-Year Community college graduate __ Some college __ 4-year college graduate __ Graduate School

__ Other

FATHER INFORMATION

FIRST NAME: __________________ **LAST NAME:** ____________________

STREET ADDRESS: ____

CITY: ________________________________ **STATE:** ___________ **ZIP CODE:** _______________

PRIMARY CAREGIVER INFORMATION

PLEASE CHECK HERE IF THE MOTHER IS NOT THE PRIMARY CAREGIVER FOR THE CHILD: ___

PLEASE IDENTIFY THE PRIMARY CAREGIVER RELATIONSHIP TO THE CHILD (If not the mother)

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

PRIMARY CAREGIVER: FIRST NAME __________________________________ **LAST NAME** ________________________________

STREET ADDRESS: ____

CITY: ________________________________ **STATE:** ___________ **ZIP CODE:** _______________

CHILD INFORMATION

CHILD #1: BIRTH INFORMATION

CHECK HERE IF BABY HAS NOT BEEN BORN: ____ **DUE DATE:** _________

CHILD #1: DEMOGRAPHIC INFORMATION

FIRST NAME: _________________________ **MIDDLE NAME:** _________________ **LAST NAME:** __________________________

DATE OF BIRTH: ________________

BABY'S SEX: __ **Male** __ **Female** **BIRTH PLURALITY:** __ **Single** __ **Twin** __ **Triplet** **BIRTH ORDER:** __ **1** __ **2** __ **3**

CHILD INFORMATION

CHILD #2: BIRTH INFORMATION

CHECK HERE IF BABY HAS NOT BEEN BORN: ____ **DUE DATE:** _________

CHILD #2: DEMOGRAPHIC INFORMATION

FIRST NAME: __________________ **MIDDLE NAME:** ____________ **LAST NAME:** ______________________

DATE OF BIRTH: ________________

BABY'S SEX: ___Male ___Female **BIRTH PLURALITY:** ___Single ___Twin ___Triplet

BIRTH ORDER: __1 __2 __3 __4 __5 __6 __7 __8 __9

ADDITIONAL CHILDREN: Check here if the Mother (or Caregiver) requires cribs for 3 or more children __

If 3 or more children are present, please enter their Demographic information from questions above: ______________________

____

OTHER INFORMATION

DID YOU SMOKE DURING PREGNANCY? : __ Yes __ No **DO MEMBERS OF YOUR HOUSEHOLD SMOKE? :** __ Yes __ No

If yes, do they smoke inside the house? __Yes __ No

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

PLEASE IDENTIFY THE FEEDING TYPE FOR YOUR BABY: __ Bottle Feeding __ Breast Feeding __ Both __ N/A

DOES YOUR BABY USE A PACIFIER? : __Yes __ No __ _N/A

DOES YOUR BABY SLEEP ON A FIRM MATTRESS? : __ Yes __ No __ N/A

WAS AN INFANT SURVIVAL KIT DISTRIBUTED? (*Required) : ___Yes ___No

IF AN INFANT SURVIVAL KIT WAS DISTRIBUTED TO THE MOTHER, PLEASE IDENTIFY THE LOCATION (Including the Indiana County : ____

WAS INFANT SURVIVAL KIT EDUCATION PROVIDED TO THE CAREGIVER? (*Required): ___Yes ___No

IF YES, WHO PROVIDED THE EDUCATION? : ____

CURRENT SLEEP LOCATION AT HOME: __ Adult Bed __ Baby Crib __ Car Seat __ Sofa/Chair

___Other **IF OTHER, PLEASE SPECIFY** ___________________________________

CURRENT SLEEP LOCATION AT THE CAREGIVERS: __ Adult Bed __ Baby Crib __ Car Seat __ Sofa/Chair __ Other

IF OTHER, PLEASE SPECIFY __________________________

CURRENT SLEEP POSITION AT HOME: ___Stomach ___Back ___Side

CURRENT SLEEP POSITION AT THE CAREGIVERS: ___Stomach ___Back ___Side

DOES THE PRIMARY CAREGIVER RECEIVE (Check all that apply) : ___WIC ___CHIP ___Food Stamps ___Medicaid

CHILDCARE TYPE: ___Childcare Center ___Home-based Daycare ___Daycare Center ___Relative/Friends ___ N/A

HOW MANY CRIBS DID YOUR CLIENT RECEIVE TODAY?: ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 or More

WAS THE HOLD HARMLESS AGREEMENT SIGNED?: ___Yes ___No

SUBMITTED BY:

FIRST NAME ______________________________ **LAST NAME** _________________________________

PHONE NUMBER _____________________________

SITE NAME ____