Safe Kids Oakland County's Safe Sleep Program Eligibility Form

PRINT CLEARLY Full Name of the Caregiver: _____

As the parent or legal guardian of the child/children receiving the Cribette play yard, "I certify the child receiving the safe sleep resources (including but not limited to a Cribette play yard portable crib and a Snoozzzette wearable blanket) are **CURRENTLY** enrolled in the following program or programs. I also will not sell or transfer ownership of the Cribette play yard to anyone who has not attended a safe sleep presentation from Safe Kids Oakland County. I also understand and agree that the sole purpose of this program is to help reduce the incidence of unsafe sleep practices and that the presentation and resources (including but not limited to the portable crib) are being provided as a free educational service to me. I realize that the program sponsors, Henry Ford Health, and their employees cannot fully evaluate the quality, safety, or condition of my safety devices (including but not limited to the portable crib). Furthermore, I understand that the actions taken in this program will not guarantee my child's safety while sleeping or using the crib. I understand that it is important to read and follow the instruction manual. For these reasons, I hereby release any program participants and any participating organizations or individuals, including the site owner, from any present or future liability from any injuries or damages that may result from the child sleeping, using the crib or otherwise. "

___ Referral from health department or other agency
___ Women, Infants, and Children (WIC)
___ Partnership. Accountability. Training. Hope. (PATH) Cash Assistance
___ Refugee Assistance Program
___ Children's Special Health Care Services
___ MI Child
___ Head Start or Great Start
___ Medicaid
___ Children with Special Needs Fund
___ Maternal Infant Health Provider (MIHP) services (or other home visitor program)
___ Native American Outreach Program
___ Family Independence Programs
___ Social Security/Disability
___ Bridge Card/food assistance
___ Emergency replacement after fire (a fire report required)
___ Court referral or other court document
___ Proof of child in foster care by foster parent or reunification plan

_____ _____

Parent/Guardian signature Date

Primary Caregiver Full Name: _____ Infant DOB/Expected DOB: ___/____/_____

Relationship to Infant: ☐ Parent ☐ Grandparent ☐ Guardian ☐ Other: _____

Zip Code of Primary Residence: _____

Race/Ethnicity of Infant

- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Hispanic or Latino
- ☐ Asian or Pacific Islander
- ☐ Native American or Alaska Native
- ☐ Prefer not to answer
- ☐ Other _____

What is your (the caregiver's) preferred language?

_____

Did you (the birthing parent) receive prenatal care?

- ☐ Yes
- ☐ No

Does anyone living in the house smoke? ☐ Yes ☐ No

This includes cigarettes, vaping (both tobacco & THC pens) marijuana, etc.

Are you (the caregiver) enrolled in Medicaid/ other public insurance?

☐ Yes ☐ No

Prior the safe sleep training, did you plan (or are currently using) a different sleeping environment than a crib/ pack n'play? *e.g adult bed, couch, car seat, etc.* ☐ Yes ☐ No

Do you (the caregiver) currently or intend to breastfeed?

☐ Yes ☐ No

Do you (the caregiver) currently or intend to use a pacifier during sleep?

☐ Yes ☐ No

Do you currently have a safe sleep area for the child to sleep?

e.g. a separate sleeping area for the child on a firm mattress without any blankets, toys, or bumper pads

☐ Yes ☐ No