INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: _____

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date

Authorized Representative's Name (Primary Contact)	Phone Number

Authorized Representative's Name (Secondary Contact)	Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in:

☐ Crib ☐ Play Yard ☐ Other (Specify) _____

What are the Infant's usual sleeping hours?

_____ _____

_____ _____

What is the infant's average length of the Infant's nap(s) during the day time?

_____ minutes _____ hours

Does the infant use a pacifier?

☐ Yes ☐ No ☐ Sometimes

If **yes**, brand: _____

SECTION C: INFANT'S ABILITY TO ROLL

My child, _____ is able to roll from their back to their stomach and stomach to their back beginning _____ / _____ / _____.

Authorized Representative Signature	Date

SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date

Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? ☐ Yes ☐ No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature	Date

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