Healthy Mothers,
Healthy Babies
The Montana Coalition

Safe sleep FOR BABY

Safe Sleep Kit Order Form

Date: _____

Child's Name: _____ **Due Date or DOB:** _____

Primary Caregiver's Name: _____

County/ Organization/ Reservation:

_____

Program name: _____

Agency: _____

Program Contact Name: _____

Contact Phone Number: _____**Contact Email:**

Shipping Address: _____

_____

_____

Remarks: *(A quick comment on how this program will help this family assists us greatly in fundraising. We always de-identify the information shared.)*

_____

_____

_____

Please email orders to:
hmhb@hmhb-mt.org

Or mail orders to:
HMHB
318-20 N. Last Chance Gulch, Ste. 2C
Helena, MT 59601
www.hmhb-mt.org
406-449-8611

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Release Form

This crib is being provided to me at no charge; this crib meets the Child Consumer Product Safety Commission standards; and this program, program organizers, County Health Department and employees, and other implementing organizations cannot fully guarantee my child's safety in this crib.

I understand that:

1. The s**afest place for babies to sleep is in their own crib in their parent's room** and the **safest position is on their back**.
2. I also understand that **exposure to cigarette smoke increases my baby's risk of Sudden Infant Death Syndrome.**

Therefore:
I hereby release Healthy Mothers, Healthy Babies, The Montana Coalition, Inc. and _____ from any present or future liability for any injuries or damages that may result from the use of this crib.

Signature:_____ **Date:**_____

Printed Name:_____

Relationship to Infant: _____

Witness:

Signature:_____ **Date:**_____

Printed Name:_____