Alberta Health Services

Last Name	First Name	Initial
Birthdate *(yyyy-Mon-dd)*		Age
PHN#		Sex ☐ M ☐ F

Well Infant Accommodation Acknowledgement of Responsibility

You are requesting accommodation of your Well Infant(s) during your hospitalization for the purposes of

- ☐ fostering parental-infant bonding
- ☐ promoting breastfeeding
- ☐ meeting the patient's healthcare needs

Well Infant Information

Name *(last, first)*	Date of birth *(yyyy-Mon-dd)*
Does the infant require acute medical care ☐ Yes ☐ No	
Infant's Primary Health Care Provider *(last, first name)*	Phone
List any information that may be helpful in facilitating this request for you and your family:	

Designated Alternate Caregiver(s)

I acknowledge that I have been named as a Designated Alternate Caregiver for this Well Infant and confirm that I understand and accept the responsibilities of this role.

Name *(last, first)*	Signature	Relationship to patient	Phone Number
Name *(last, first)*	Signature	Relationship to patient	Phone Number
Name *(last, first)*	Signature	Relationship to patient	Phone Number

Patient Authorization

I acknowledge that I have designated the above noted individual(s) as Designated Alternate Caregiver(s).

Signature	Date of Birth *(yyyy-Mon-dd)*

Alberta Health Services

Last Name	First Name	Initial
Birthdate *(yyyy-Mon-dd)*		Age
PHN#		Sex ☐ M ☐ F

Well Infant Accommodation Acknowledgement of Responsibility

Patient Acknowledgement of Responsibility

By signing below you acknowledge that during your hospitalization:

- The care of your Well Infant(s) is you and/or your Designated Alternate Caregiver's sole responsibility.
- A Designated Alternate Caregiver for the Well Infant(s) must be available 24 hours a day, 7 days a week to ensure care of the infant whenever you are unable to independently provide all care necessary for the infant. Although you may list more than one Designated Alternate Caregiver, only one Designated Alternative Caregiver is required to be present with you at any time.
- Alberta Health Services (AHS) will not provide monitoring or assessments of your Well Infant(s) on this unit. You or your family/Designated Alternate Caregiver should continue with routine infant assessments as recommended by the infant's Health Practitioner *(i.e., family physician, pediatrician, nurse practitioner or midwife).*
- AHS shall provide an infant bassinet and linen. All other supplies needed to care for your Well Infant(s) shall be provided by you and your family.
- At anytime after approval of the Well Infant(s)'s accommodation, if the safety or well-being of anyone becomes a concern as a result of the accommodation; the manager or designate has the authority to limit visitation or ask that the Well Infant(s) be taken home.
- You, your family and your Designated Alternate Caregiver shall abide by all safety requirements, including the *Safe Infant Sleep Policy*, which recommends not bed sharing with infant(s).
- If your Well Infant(s) develops a health concern, you/your family/Designated Alternate Caregiver shall make arrangements for the infant(s) to be assessed by his/her Health Practitioner *(i.e., family physician, pediatrician, nurse practitioner or midwife)* or take the infant(s) to the Emergency Room. In the unlikely event that your Well Infant(s) develops a life threatening medical emergency, it will be managed in accordance with established AHS protocols.

Waiver & Indemnity: Well Infant Accommodation

In consideration of Alberta Health Services allowing my Well Infant(s) to stay with me while I am hospitalized:

- I accept all risks and waive and release Alberta Health Services, those for whom it is responsible at law and its privileged physicians from any liability and responsibility for all harm, consequences, losses and claims of any nature *(including negligence)*, including third party claims, arising from or in any way relating to the accommodation of my Well Infant(s).
- I agree to indemnify and hold harmless Alberta Health Services, those for whom it is responsible at law and its privileged physicians, from any claim arising from or in any way related to the accommodation of my Well Infant(s).
- This Waiver and Indemnity is binding upon myself, my heirs, executors, administrators, personal representatives and assigns.

I understand that I have the right to seek independent legal advice from a lawyer of my choosing prior to signing this Waiver and Indemnity. I understand that by signing this I am waiving certain legal rights, including the right to sue, which I may have against Alberta Health Services, those for whom it is legally responsible and its privileged physicians.

Patient Name *(print)*	Signature	Date *(yyyy-Mon-dd)*
Witness Name *(print)*	Signature	

Patient Care Manager Approval

I consider it appropriate for this patient to have their Well Infant(s), stay with them while they are hospitalized.
I have made the patient's Health Care Practitioner aware of this arrangement and he/she has not raised any concerns for this patient having their Well Infant(s) stay with them while they are hospitalized.

Admitting physician name *(print)*		Phone
Manager name *(print)*	Manager's Signature	Date *(yyyy-Mon-dd)*