D H E C

PROMOTE PROTECT PROSPER

South Carolina Department of Health and Environmental Control

SHAKEN BABY SYNDROME EDUCATION VERIFICATION STATEMENT

Hospital/Birth Center Instructions: Complete one form for each infant. Provide parent(s) with an opportunity to view an approved video presentation about shaken baby syndrome, and information about the importance of learning infant CPR. Request that the parent(s) or guardian verify that the video and information has been made available to them by signing the section below. Only one signature is required. File the form in the baby's medical record.

HOSPITAL NAME: _____
(Hospital/Birth Center)

BABY'S LEGAL NAME: _____

DOB: _____ **SEX:** ☐ M ☐ F
(MM/DD/YY)

Parent Verification: I have been offered the opportunity to view a video presentation on the dangers associated with shaking infants and small children. I have also been given information about the importance of learning infant CPR. I voluntarily sign this statement acknowledging that I have received, read, and understood the information and been offered the opportunity to view the video.

ONLY ONE SIGNATURE IS REQUIRED.

SIGNATURE, MOTHER: _____ **DATE:** _____
(MM/DD/YY)

MOTHER REFUSED TO SIGN ☐

SIGNATURE, FATHER: _____ **DATE:** _____
(MM/DD/YY)

FATHER REFUSED TO SIGN ☐

SIGNATURE, OTHER: _____ **DATE:** _____
(step-parent, adoptive parent, legal guardian, legal custodian) (MM/DD/YY)

OTHER REFUSED TO SIGN ☐

Hospital Representative: _____ **DATE:** _____
(MM/DD/YY)

This form and accompanying information provided in compliance with Act 176 of 2002 (11 P.S. §2121-2126); SC Code of Laws §44-37-50, effective January 1, 2008.