

PATIENT SAFETY VIDEO
Never, Ever Shake a Baby

PARENT SIGNATURE FORM

I. I/We understand that the purpose of viewing *Never, Ever Shake a Baby* is to make parents aware of the dangers of shaking infants and young children, and the symptoms of Shaken Baby Syndrome/Abusive Head Trauma. I/We understand it is important for both parents to watch this video.

II. I/We confirm that I/we have watched the video on the dangers of shaking infants and young children, and the symptoms of Shaken Baby Syndrome/Abusive Head Trauma. If the other parent is unavailable, I have checked the box below to confirm that the other parent is unavailable but I will use my best efforts to tell him/her about the information presented in this video.

CHECK HERE IF THE OTHER PARENT IS UNAVAILABLE

Parent 1 Signature Date

Parent 2 Signature Date

Parent 1 Name (printed)

Parent 2 Name (printed)

III. The (name of hospital or birth center) has requested that I/we watch the video on the dangers of shaking infants and young children, and the symptoms of Shaken Baby Syndrome/Abusive Head Trauma. I/We decline to watch this video.

Parent 1 Signature Date

Parent 2 Signature Date

Parent 1 Name (printed)

Parent 2 Name (printed)