

Infant's Information

Last _____ First _____ M. _____ Case Number _____

1 Identify all persons who were in contact with the infant in the 24 hours prior to the infant's death.
(being in the same room, living in/staying in/visiting the infant's primary residence - if more than 3 persons, use additional pages)

	Person 1	Person 2	Person 3
a) Last name of person.....	_____	_____	_____
b) First name of person.....	_____	_____	_____
c) Maiden Name <i>(if applicable)</i>	_____	_____	_____
d) Relationship to infant.....	_____	_____	_____
e) Street.....	_____	_____	_____
f) City.....	_____	_____	_____
g) State.....	_____	_____	_____
h) DOB	Month / Day / Year	Month / Day / Year	Month / Day / Year
i) Where did contact with the infant occur <i>(ex. house, daycare, playground)</i>	_____	_____	_____
j) Date of last contact with the infant.....	Month / Day / Year	Month / Day / Year	Month / Day / Year
k) Approximate time of last contact with the infant	Military Time	Military Time	Military Time
l) During the <u>week</u> prior to the infant's death, was this person sick? <i>(If "Yes", explain the circumstances below)</i>	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓
m) For persons biologically related to the infant <i>(d above)</i> are there any known conditions/diseases that run in the family? <i>(down syndrome)</i>	<input type="checkbox"/> Not applicable <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Not applicable <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Not applicable <input type="checkbox"/> No <input type="checkbox"/> Yes ↓
n) Has this person experienced the death of any of their own children or of any other children while in their care?.....	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes ↓
l) Child's name.....	_____	_____	_____
II) Relationship to caregiver	_____	_____	_____
III) Date of death.....	Month / Day / Year	Month / Day / Year	Month / Day / Year
IV) Child's age at death <i>(years or months if <2 years)</i>	_____	_____	_____
V) Cause of death	_____	_____	_____
VI) Place of death <i>(City/State)</i> ...	_____	_____	_____

2 Did the infant visit a location with large numbers of people within the last 24 hours? No Yes ⇨ Please describe: _____

3 Are there any factors, circumstances, or environmental concerns?
(ex. mother smoked while breast feeding, exposed to a large number of people at church or a public event, air travel)

No Yes ⇨ Please describe: _____

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4 Daycare

Did the infant visit a daycare in the 24 hours prior to the death?

Yes No

How many adults were supervising the children?

_____ Number of people (18 years or older)

Were any of these adults sick?

No Yes ⇨ Specify: _____

How many children were under the care of the provider at that day?

_____ Number of children (under 18 years)

Identify any children in daycare who were sick and were in contact or close proximity to the infant in the 24 hours prior to the death? Child _____ Child _____ Child _____

a) First name of child _____

b) Last name of child..... _____

c) Date of birth Month / Day / Year Month / Day / Year Month / Day / Year

d) Where did contact with the infant occur (ex. house, daycare, playground)

e) Date of last contact with the infant Month / Day Month / Day Month / Day

f) Approximate time of last contact with the infant Military Time Military Time Military Time

g) During the week prior to the infant's death, was this person sick? (If "Yes", explain the circumstances below) Unknown No Yes ↓

If more than 3 children, use additional pages

Section completed on _____/_____/_____ at _____:_____ by _____

How conducted: In person Telephone Other _____