

Child Passenger Safety Seat Distribution Referral Form (Revised 8-21-18)

Jones County Health Department Car Passenger Seat Initiative

<u>Demographics:</u>	
Parent/Guardian's Name:	
Parent/Guardian's Address:	
Primary Telephone #:	Secondary #:
Eligibility:	
Is family receiving Public Assistance?	□ No □ Yes
If no, what is the reason for the referral?	
If yes, what type of Public Assistance is be	eing received?
Family Information:	
How old is the child for whom the referral	is being made?
Please mark, if known: Child's Weight:	lbs. Child's Height:ftinches
If the mother is pregnant, what is her expe	cted due date?
Car Seat (please ✓ preferred seat):	EvenFlo Sure Ride Convertible Seat (5 lbs. – 65 lbs.)Safety 1 st Alpha Elite 3-in-1 Seat (5 lbs. – 100 lbs.)
Referral information:	
Person making the referral:	
Agency representing, if applicable:	
Date of referral:	
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JCHD COORDINATORS:	
DATE RECEIVED:	
COMPLETED PAPERWORK RETURNED TO C	COORDINATOR: