



Public Health
Prevent. Promote Protect.

Reynolds County Health Center
In cooperation with Department of Health of Missouri
2323 Green Street, P.O. Box 40
Centerville, MO 63633
Phone: (573) 648-2498

Safety Seat Program Information Sheet

Date: _____

Parent/Guardian Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

If Prenatal, Expected Date of Delivery: _____

First Car Seat: ___ Yes ___ No Replacement: ___ Yes ___ No

If replacement, please state reason _____

Name of child requiring safety seat: _____

Date of birth of child requiring safety seat: _____

Where did you hear of our safety seat program?

___ Friend ___ Social Media ___ Referral , if referred who referred you? _____

My signature below indicates that I agree I have received and understand instructional education on installation and usage. I will use the safety seat to promote the safety of my child. If any injury should occur due to improper use or installation or product failure, I accept full responsibility and will not hold Reynolds County Health Center or any of the employees responsible.

Signature: _____ Date: _____

Employee Signature: _____ Date: _____