

**INFORMATION FORM
TEDDY BEAR STICKER PROGRAM**



1. Complete Information form for each child age eight (8) or younger (regardless of seat usage).
2. Completing this form will ensure replacement of stickered child safety seats involved in the crash.
3. Email this form back to injury@dph.ga.gov

SECTION A.

PCR Number: _____		Responder's Name: _____	
Emergency Response Agency: _____			
Address: _____		Phone: _____	
City: _____	State: _____	Zip Code: _____	
Child Safety Seat Replacement Agency: _____			
Address: _____		Phone: _____	
City: _____	State: _____	Zip Code: _____	

SECTION B.

Child's Date of Birth _____ (MM) (DD) (YYYY)	Child's Age _____ years _____ months (if < 1yr)
Date of crash _____ (MM) (DD) (YYYY)	City of crash scene: _____
County of crash scene: _____	County of residence: _____

SECTION C.

1. Was the child in the vehicle at the time of the crash? Yes No
2. What type of restraint was used for the child?

<input type="checkbox"/> No Restraint	<input type="checkbox"/> Forward-facing child safety seat with harness
<input type="checkbox"/> Lap/shoulder seat belt	<input type="checkbox"/> Booster Seat (no back or high back w/o harness)
<input type="checkbox"/> Lap only seat belt	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Rear-facing child safety seat	
3. Was a Teddy Bear Sticker affixed anywhere on the child safety seat (back, sides, bottom, etc.)?
 Yes No Unknown Not Applicable (e.g. no child safety seat)
4. Which best describes the location of the child in the vehicle at the time of the crash?

<input type="checkbox"/> Back Seat – Passenger side	<input type="checkbox"/> Back Seat – Center position	<input type="checkbox"/> Back Seat – Driver side
<input type="checkbox"/> Front Seat – Passenger side	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify) _____
5. Did the child experience an injury due to the motor vehicle crash?
 No Yes (if yes, please specify type of injury) _____ Unknown
6. Was the child transported to a medical facility?
 No Yes (if yes, please specify facility name) _____ Unknown
7. Was the child admitted into the medical facility?
 No Yes Unknown
8. Was anyone else in the crash transported to a medical facility?
 No Yes Unknown

SECTION D.

For stickered seats only - Please indicate the type of child safety seat needed to replace the seat involved in the crash.

<input type="checkbox"/> Convertible (rear- or forward-facing with harness)	<input type="checkbox"/> Combination (forward-facing with harness / booster)
<input type="checkbox"/> High Back Booster Seat	<input type="checkbox"/> No Back Booster Seat

Please indicate your top 2 choices for incentive items.

<input type="checkbox"/> Bike / Skate Helmets	<input type="checkbox"/> Buckle Bears	<input type="checkbox"/> Buckle Up Frisbees	<input type="checkbox"/> Safety Coloring Books (English)
<input type="checkbox"/> Window Clings	<input type="checkbox"/> Buckle-Up Stickers	<input type="checkbox"/> Safety Brochures	<input type="checkbox"/> Safety Coloring Books (Spanish))
<input type="checkbox"/> Sleep Baby Hard Back Book on Safe Sleep for Caregivers			

SHIPPING ADDRESS FOR INCENTIVES (Shipping Address MAY NOT be a P.O. Box)

Name: _____		Phone: _____	
Address: _____			
Address 2 (e.g. suite): _____			
City: _____	State: GA	Zip Code: _____	