



STATE OF ALASKA  
DEPARTMENT OF CORRECTIONS

## Lactation Program Agreement

Prisoner Full Name: \_\_\_\_\_ Offender #: \_\_\_\_\_

**In order to participate in the lactation (breast pumping) program, I acknowledge and agree to adhere to the following:**

- Participation in the breast pumping program requires a written order from the facility's health care provider.
- I agree to submit to regular drug screens while I am participating in the lactation program. I understand that test results shall be released to security staff and that positive test results shall be reported to OCS.
- I understand that one positive drug screen will result in my being discharged from the lactation program.
- I will follow instructions on the storage and handling of expressed breast milk.
- Upon the health care provider's order, the following items shall be issued and kept in my room for the duration of pumping and up to a maximum of six (6) months following the birth of my child:
  - breast pump, tubing, breast cups and collection bottles/containers;
  - pen for labeling containers with my name, ACOMS number and date of pumping;
  - small container of dish washing soap to clean equipment;
  - one extra bath towel and a small stack (30 sheets) of paper towels to dry equipment;
  - breast pads to prevent milk leakage from soaking clothing;
  - one extra bra and one extra state-issued t-shirt.
- I understand that if I have an open case with OCS, OCS will need to approve my participation in this program.
- I will follow instructions on assembly, use, disassembly, and cleaning of the breast pump.
- I am responsible to use and clean equipment and other issued items only as instructed.
- I acknowledge that security staff may inspect any equipment and other issued items at any time for any reason.
- I will notify security staff immediately if any equipment or other issued items are unaccounted for.
- I will be housed in a single cell if available and if not, the other prisoner must agree to such housing. I understand that DOC cannot guarantee privacy for breast pumping.
- I will pump my breasts according to my schedule (usually every 3 to 4 hours around the clock) but I will not pump during count times.
- There will be a locked freezer in medical for which designated staff will have a key.
  - Immediately after pumping, breast milk must be secured in the freezer.



STATE OF ALASKA  
DEPARTMENT OF CORRECTIONS

- When pumping at night or after lights out, milk will be discarded.
- The container must be marked with my name, offender number and the date it was placed in the freezer.
- If I do not label the container as required, the breast milk will be discarded.
- I may designate up to three visitors who are authorized to pick up my breast milk. I will inform the visitor to bring a cooler for the breast milk.
- Breast milk must be picked up at least every seven (7) days and I understand that milk dated over seven days will be discarded.
- I acknowledge that if there are three (3) consecutive weeks of missed pickups, my participation in the lactation program will be discontinued.
- I will notify medical prior to a meeting with a visitor who has been approved to pick up the milk. All containers of milk will be transported to the visiting area. I will allow security staff in the visit area to inspect the bag/container prior to giving it to the visitor.
- I will transfer the bag/container to the visitor in the immediate presence of security staff. I will not pass anything else or receive anything from the visitor during this visit.
- I acknowledge that staff will not arrange or pay for the pickup of the breast milk at the facility or provide a cooler or any other container for transporting the breast milk, other than plastic bottles or cups and plastic bags. Breast milk will not be delivered or shipped to anyone in the community under any circumstances.
- I agree to not hold the Department of Corrections or any of its staff responsible for the safety or quality of the breast milk.
- I have read or had read to me this agreement and acknowledge and agree to adhere to this agreement.
- I acknowledge that participation in this program is dependent upon adherence to this agreement.
- I understand that decisions to discharge me from the lactation program may not be appealed and are not grievable.

\_\_\_\_\_  
Prisoner Printed Name / Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Staff Witness Printed Name / Signature:

\_\_\_\_\_  
Date: