Mother's Worksheet for Child's Birth Certificate

Date of Birth: _____ Time of Birth: _____am/pm

Mothers Contact Info: Name _____ Phone Number_____

The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship and parentage. This document will be used by your child throughout his/her life, therefore it is very important that you provide complete and accurate information to all of the questions.

PLEASE PRINT CLEARLY

1. **What is your baby's legal name (as it should appear on the birth certificate)?** **Gender:** ☐ - Male ☐ - Female

_____

First Middle Last Suffix (Jr., III, etc.)

2. **Do you want a Social Security Number issued for your baby?** ☐ - YES ☐ - NO

3. **Physical address where your home birth took place:** _____

Street address City Zip code

MOTHER'S INFORMATION:

4. **What is your current legal name?**

_____

First Middle Last Suffix (Jr., III, etc.)

5. **What was your full name PRIOR to your first marriage?**

_____

First Middle Last Suffix (Jr., III, etc.)

6. **Marital Status:**

☐ - Never Married

If not married, do you and the baby's father intend to complete an Affidavit of Parentage (AOP) in which he acknowledges that he is the natural father and accepts legal responsibility for the child? Both parents must be in agreement and present to complete the form (a Government issued photo ID will be required for the father**). If you are not married and an affidavit of parentage is not completed, information about the father cannot be included on the birth certificate.

☐ - Yes, I would like to complete an affidavit of parentage

☐ - No, I do not choose to complete an affidavit of parentage

☐ - Married ☐ - Divorced - Date of Divorce: _____/_____/_____

☐ - Separated ☐ - Widowed - Date Widowed: _____/_____/_____

7. **What is your date of birth? (Example: July 4, 1977):** _____

8. **In what state, US territory, or foreign country were you born?** _____

9. **What is your Social Security Number?** ☐☐☐-☐☐-☐☐☐☐

10. **What is the highest level of schooling that you will have completed at the time of delivery?**

(Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received).

☐ - 8th grade or less ☐ - 9th – 12th grade, no diploma ☐ - High school graduate or GED completed

☐ - Some college credit, but no degree ☐ - Associate degree (e.g., AA, AS) ☐ - Bachelor's degree (e.g., BA, AB, BS)

☐ - Master's degree (e.g., MA, MS, MEng., Med, MSW, MBA)

☐ - Doctorate (E.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, LLB, JD)

11. **What is your <u>physical</u> address?**

Street Address City State Zip Code

County: _____ **Inside City limits? ☐ - Yes ☐ - No**

Is it the same as your mailing address? ☐ - Yes ☐ - No - If no, please include mailing address below:

PO Box City State Zip Code

12. **Are you Spanish/Hispanic/Latina?**

If not Spanish/Hispanic/Latina, check the "No" box. If Spanish/Hispanic/Latina, check the appropriate box.

☐ - No, not Spanish/Hispanic/Latina ☐ - Yes, Mexican, Mexican American, Chicana

☐ - Yes, Puerto Rican ☐ - Yes, Cuban

☐ - Yes, other Spanish/Hispanic/Latina (e.g., Spaniard, Salvadoran, Dominican, Columbian)

Specify:_____

13. **What is your race?** *(Please check one or more races to indicate what you consider yourself to be):*

☐ - White ☐ - Black or African American

☐ - American Indian or Alaska Native (name of enrolled or principal tribe) _____

☐ - Asian Indian ☐ - Chinese ☐ - Filipino ☐ - Japanese ☐ - Korean ☐ - Vietnamese

☐ - Other Asian (specify) _____ ☐ - Native Hawaiian

☐ - Guamanian or Chamorro ☐ - Samoan ☐ - Other Pacific Islander (specify):_____

☐ - Other (specify):_____

FATHER'S INFORMATION:

14. **What is the current legal name of your baby's father?**

First Middle Last Suffix (Jr., III, etc.)

Is the baby's father your husband? ☐ - Yes ☐ - No

15. **What is the father's date of birth? (Example: March 4, 1976)** : _____

☐ - Don't know

16. **In what state, US territory, or foreign country was the father born?:** _____

17. **What is the father's Social Security Number?** ***If you are not married, and an affidavit of parentage has not been completed, leave this item blank.***

☐☐☐-☐☐-☐☐☐☐

18. **What is the highest level of schooling that the father will have completed at the time of delivery?**

(Check the box that best describes his education. If he is currently enrolled, check the box that indicates the previous grade or highest degree received).

☐ - 8th grade or less ☐ - 9th-12th grade, no diploma ☐ - High school graduate or GED completed

☐ - Some college credit, but no degree ☐ - Associate degree (e.g., AA, AS) ☐ - Bachelor's degree (e.g., BA, AB, BS)

☐ - Master's degree (e.g., MA, MS, MEng., Med, MSW, MBA)

☐ - Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ - Unknown

19. **Is the father's residence the same as the mother's?** ☐ - YES ☐ - NO

If different, please list below:

Street Address City State Zip Code

20. **Is the father Spanish/Hispanic/Latino?**

If not Spanish/Hispanic/Lation, check the "No" box. If Spanish/Hispanic/Latino, check the appropriate box.

☐ - No, not Spanish/Hispanic/Latino ☐ - Yes, Mexican, Mexican American, Chicano

☐ - Yes, Puerto Rican ☐ - Yes, Cuban

☐ - Yes, other Spanish/Hispanic/Latino (e.g., Spaniard, Salvadoran, Dominican, Colombian)

(Specify): _____

21. **What is the father's race?**

(Please check one or more races to indicate what he considers himself to be).

☐ - White ☐ - Black or African American

☐ - American Indian or Alaska Native (name of enrolled or principal tribe) _____

☐ - Asian Indian ☐ - Chinese ☐ - Filipino ☐ - Japanese ☐ - Korean ☐ - Vietnamese

☐ - Other Asian (specify) _____

☐ - Native Hawaiian ☐ - Guamanian or Chamorro ☐ - Samoan ☐ - Other Pacific Islander (specify)

☐ - Other (specify)

MOTHER'S PRENATAL INFORMATION: To be filled out by Mother and /or Midwife

22. **Did you receive WIC (Women, Infant and Children) food for yourself because you were pregnant with this child?**

☐ Yes ☐ No ☐ Unknown

23. **Principal source of payment for this delivery:** ☐ Medicaid ☐ Private Ins. ☐ Self Pay ☐ Other _____

24. **Did mother receive prenatal care?** ☐ - YES ☐- NO

Date of first prenatal visit: _____ **Date of last prenatal visit:**_____ **Total Number of Prenatal Visits:**_____

25. **Number of previous live births (do not include this child):** _____ **Number now living:** _____

Number of previous live births now dead: _____ **Date of last live birth (do not include this child):**_____

Number of other pregnancy outcomes (miscarriage, termination, etc.): _____ **Date of last other outcome:**_____

26. **Risk Factors during this pregnancy:**

Diabetes: ☐ - Pre-pregnancy ☐ - Gestational

Hypertension: ☐ - Pre-pregnancy ☐ - Gestational ☐ Eclampsia

☐ - Previous Pre-term Births ☐ - Other previous poor pregnancy outcome

☐ - Fertility enhancing drugs, artificial insemination or intrauterine insemination

☐ - Assisted reproductive technology ☐ - Mother had a previous cesarean delivery

☐ - None of the Above

27. **What is your height?** _____ **Feet** _____ **Inches**

28. **What was your pre-pregnancy weight:** _____**lbs.** **Weight at delivery** _____**lbs.**

29. **Date last normal menstrual period began:** _____

30. **Infections present and/or treated during this pregnancy:**

☐ - Gonorrhea ☐ - Syphilis ☐ - Chlamydia ☐ - Hepatitis B ☐ - Hepatitis C

☐ - None of the Above

☐ - Mother tested for HBSaAG? ☐ - Yes ☐ - No If yes, date tested: _____ Test result: _____

31. **Obstetric Procedures:**

☐ - Cervical Cerclage ☐ - Tocolysis ☐ - External cephalic version

☐ - None of the Above

32. **How many cigarettes did you smoke on an average day during each of the following time periods?**

If you NEVER smoked, enter zero for each time period.

- Three months before pregnancy: _____
- First three months of pregnancy: _____
- Second three months of pregnancy: _____
- Third trimester of pregnancy: _____

33. **Onset of Labor:**

☐ - Premature Rupture of the Membranes (prolonged >12 hours)

☐ - Precipitous Labor (less than 3hours)

☐ - Prolonged Labor (greater than 20 hours)

☐ - None of the Above

34. **Characteristics of Labor and Delivery: (Check ALL that Apply)**

☐ - Induction of Labor

☐ - Augmentation of Labor

☐ - Non vertex presentation

☐ - Steriods given to the mother prior to delivery
☐ - Antibiotics given to the mother during labor
☐ - Clinical chorioamnionitis diagnosed during labor or maternal temp >100.4
☐ - Moderate/heavy meconium staining of the amniotic fluid
☐ - Fetal intolerance of labor was such that one or more of the following actions was taken:
in-utero resuscitative measures, further fetal assessment, operative delivery.
☐ - Epidural or spinal anesthesia during labor
☐ - None of the above

35. **Method of Delivery:**

A. Was delivery with forceps attempted but unsuccessful? ☐ - YES ☐ - NO

B. Was delivery with vacuum extraction attemtped but unsuccessful? ☐ - YES ☐- NO

C. Fetal presentation at birth (check one): ☐ - Cephalic ☐ - Breech ☐ - Other

36. **Final route and method of delivery (check one):**

☐ - Vaginal/Spontaneous
☐ - Vaginal/Forceps
☐ - Vaginal/Vacuum
☐ - Cesarean - If cesarean, was labor attempted ☐ - YES ☐ - NO

37. **Maternal Morbidity (check all that apply):**

☐ - Maternal transfusion
☐ - Third or fourth degree perineal laceration
☐ - Ruptured uterus
☐ - Unplanned hysterectomy
☐ - Admission to intensive care unit
☐ - Unplanned operating room procedure following delivery
☐ - None of the above

38. **Is baby being breastfed?** ☐ Yes ☐No

39. **Hep. B Mom ☐ Positive ☐ Negative Date Tested:_____**

40. **Hep. B Baby Date Given:_____**

NEWBORN INFORMATION

41. **Birth Weight:** _____pounds, _____ounces

42. **Obstetric estimate of gestation at delivery (weeks):** _____

43. **APGAR Score:** _____

44. **Abnormal conditions of the newborn (check all that apply):**

☐ - Assisted ventilation required immediately following delivery
☐ - Assisted ventilation required for more than six hours
☐ - NICU Admission
☐ - Newborn given surfactant replacement therapy
☐ - Antibiotics received by the newborn for suspected neonatal sepsis
☐ - Seizure or serious neurologic dysfunction
☐ - Significant birth injury (skeletal fracture (s), peripheral nerve injury, and /or soft tissue/solid organ hemorrhage which requires Intervention)
☐ - None of the Above

45. **Congenital anomalies of the newborn:**

☐ - Anencephaly
☐ - Cyanotic congenital heart disease
☐ - Omphalocele
☐ - Meningomyelocele/Spina Bifida
☐ - Congenital diaphragmatic hernia
☐ - Gastroschisis

☐ - Limb reduction defect ☐ - Cleft Lip with or with Cleft Palate
☐ - Cleft Palate alone ☐ - Hypospadias
☐ - Down Syndrome: ☐ - Karyotype confirmed ☐ - Suspected chromosomal disorder
☐ - None of the Above

46. **Was the infant transferred within 24 hours of delivery?** ☐ - Yes ☐ - No

If yes to what facility: _____

47. **Is infant being breastfed?** ☐ - Yes ☐ - No

48. **Was infant vaccinated with Hepatitis B vaccine?** ☐ - Yes ☐ - No

If Yes, vaccination date: _____

49. **Is infant living at the time of report?** ☐ - Yes ☐ - No

50. **Certifier Information:**
This is usually a midwife, pysician, or any person present during the birth of the child (father, friend, husband, mother, etc.).

First Name: _____ **Middle Name:** _____ **Last Name:**_____

Title: _____ **(if applicable)**

Date Certified: _____

***NOTE: THIS PERSON ALSO HAS TO BE PRESENT WITH PHOTO ID TO COMPLETE BIRTH REGISTRATION WHEN MOTHER COMES IN TO THE BUNCOMBE COUNTY DEPARTMENT OF HEALTH VITAL RECORDS OFFICE.**