

DOB \_\_\_\_\_ Time \_\_\_\_\_ am/pm Contact Name & Phone Number \_\_\_\_\_

## Mother's Worksheet for Child's Birth Certificate

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 will 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

### MOTHER'S INFORMATION:

3. What is your current legal name?

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

4. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

6. What is your date of birth? (Example: July 4, 1977) \_\_\_\_\_

7. In what state, US territory, or foreign country were you born? \_\_\_\_\_

8. What is your Social Security Number?    -   -

9. 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).

8<sup>th</sup> grade or less

9<sup>th</sup> - 12<sup>th</sup> 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)

10. What is your physical address? Is it the same as your mailing address?  Yes  No (If no, please complete P.O. Box #)

Complete number and street: \_\_\_\_\_

Apt. Number: \_\_\_\_\_ P.O. Box \_\_\_\_\_ City, Town or Location \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_ Inside City limits?  Yes  No  Don't know

**11. 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, Colombian)

Specify: \_\_\_\_\_

**12. 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:**

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

First	Middle	Last	Suffix (Jr., III, etc.)
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Is the baby's father your husband?  Yes  No

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

Don't know

**15. In what state, US territory, or foreign country was the father born? \_\_\_\_\_**

**16. 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.**

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**17. 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).

- 8<sup>th</sup> grade or less  9<sup>th</sup>-12<sup>th</sup> 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

**18. 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): \_\_\_\_\_

**19. 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**

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

Yes  No  Unknown

21. Principal source of payment for this delivery:  Medicaid  Private Ins.  Self Pay  Other \_\_\_\_\_

22. What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches

23. What was your pre-pregnancy weight, that is, your weight immediately before you became pregnant with this child?

\_\_\_\_\_ lbs. Weight at delivery \_\_\_\_\_ lbs.

24. Previous births \_\_\_\_\_ #of live births \_\_\_\_\_ Date of last live birth \_\_\_\_\_

# of terminations \_\_\_\_\_ Date of last termination \_\_\_\_\_

25. How many cigarettes OR packs of 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.

	# of cigarettes		# of packs
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Third trimester of pregnancy	_____	OR	_____

26. Date of last menstrual period \_\_\_\_\_

27. Date of first prenatal visit \_\_\_\_\_ Date of last prenatal visit \_\_\_\_\_ Total Number of Prenatal Visits: \_\_\_\_\_

28. Is baby being breastfed?  Yes  No

29. Hep. B Mom  Positive  Negative Date Tested: \_\_\_\_\_

30. Hep. B Baby Date Given: \_\_\_\_\_ (if applicable)

31. 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

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

Gonorrhea  Syphilis  Chlamydia  Hepatitis B  
 Hepatitis C  None of the Above

33. **Obstetric Procedures:**

Cervical Cerclage  Tocolysis  
 External cephalic version  None of the Above

34. **Onset of Labor:**

Premature Rupture of the Membranes (prolonged >12 hours)  
 Precipitous Labor (<3hours)  
 Prolonged Labor (>20 hours)  
 None of the Above

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

Induction of Labor  
 Augmentation of Labor  
 Non vertex presentation  
 Steroids 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

**36. Method of Delivery:**

- A. **Was delivery with forceps attempted and unsuccessful?**  Yes  No
- B. **Was delivery with vacuum extraction attempted but unsuccessful?**  Yes  No
- C. **Fetal presentation at birth (check one):**  Cephalic  Breech  Other

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

- Vaginal/Spontaneous
- Vaginal/Forceps
- Vaginal/Vacuum
- Cesarean If cesarean was labor attempted \_\_\_\_\_ Yes \_\_\_\_\_ No

**38. 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

**NEWBORN INFORMATION**

39. Birthweight: \_\_\_\_\_ lbs. \_\_\_\_\_ ounces

40. Obstetric estimate of gestation at delivery (weeks) \_\_\_\_\_

41. APGAR Score \_\_\_\_\_

**42. 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

**43. Congenital anomalies of the newborn**

- Anecephaly
- Cyanotic congenital heart disease
- Omphalocele
- Limb reduction defect
- Cleft Plate alone
  - Karyotype confirmed
  - Karyotype pending
- None of the Above
- Meningomyelocele/Spina Bifida
- Congenital diaphragmatic hernia
- Gastroschisis
- Cleft Lip with or with Cleft Palate
- Down Syndrome
- Suspected chromosomal disorder
- Hypospadias

44. **Was the infant transferred within 24 hours of delivery:**  Yes  No

If yes to what facility: \_\_\_\_\_

45. Is infant Breastfed?  Yes  No

46. Is infant living at the time of report?  Yes  No