Naming your baby and birth certificate information

Please use this worksheet to give your baby's name and your demographic information to the hospital birth registry staff. *The information you provide will be used to create your child's birth certificate.* The birth certificate is a document that proves your child's age, citizenship and parentage. This document will be used by your child throughout his/her life. State laws provide protection against unauthorized release of identifying information from birth certificates to protect the privacy of the parents and their child.

It is very important that you provide complete and accurate information to all of the questions. In addition to information used for legal purposes, other information from the birth record is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as parents' education, race, and lifestyle factors will be studied, but will not appear on the birth certificate issued to you or your child.

Birth records must be filed within 5 days of the birth. If you do not name your child within five (5) days, the record will be filed as "baby boy" or "baby girl" and no automatic Social Security Number can be issued, but you can change the name free of charge within 45 days of the birth.

Baby You can give your baby any first, middle and last name you choose. Legally, it is permissible to give your child the last name of the mother, the father, a combination of the names or another last name of your choosing. Please keep in mind that names print on the birth certificates in capital letters. Apostrophes (') and hyphens (-) can only be placed between two letters, not at the beginning or end of a name. No other special characters are permitted.
Minnesota statute requires that all births be registered within 5 days. The hospital or your homebirth midwife must submit the birth registration at that time. If a name has not yet been selected, the registration will be filed with a generic name like "baby boy" or "baby girl" and your last name. You can change your baby's name any time within 45 days using the Parent Notice you will receive from the county.

How would you like your baby's legal name to appear on the birth certificate?

Baby's name – first	**middle**	**last**

Do you wish to apply for a free **Social Security Number for your baby** now? Checking the box below authorizes the State to provide the Social Security Administration with the information from this form which is needed to assign a number. *Parent Social Security Numbers must be completed.* ☐ **Yes** ☐ **No**

If you do not wish to get one now, you can still apply for a free Social Security Number by bringing your baby's birth certificate to a Social Security Administration office. Social Security Numbers are always free, contact the Social Security Administration for more information.

How many babies in this birth? (single, twin, etc.) *If not a single birth*, what was birth order of this baby?

Contact information in case the birth registrar has any questions about information contained in this form.

Phone (1) _____ Phone (2) _____.

Mother *write your current legal name below –*

first **middle** **last**

What was your name when you were born or before you were first married (maiden name)?

Date of birth

/ /

mm/dd/yyyy

Social Security Number Furnishing parent(s) Social Security Numbers is required by Federal Law. The numbers will be made available to the Minnesota Department of Human Services to assist with child support enforcement activities and to the Internal Revenue Service. Social Security numbers do not appear on the birth certificate.

SSN: **/ /** ☐ I don't have a Social Security Number

Where were you born?: City, State (if US), Country

Where do you live (residence address)?

County of Residence?

If <u>not within city limits</u>, list name of township

Mailing address ☐ **use residence address**

Did you get WIC food during this pregnancy?
☐ **Yes** ☐ **No**
If yes - What month of pregnancy did WIC begin? (first, second, etc.)

Did you smoke cigarettes 3 months before or during this pregnancy? ☐ **Yes** ☐ **No**
If yes – number of cigarettes or packs per day
____ 3 mo before ____ First trimester
____ Second trimester ____ Third trimester
Above numbers are: ☐ **cigarettes** or ☐ **packs**

Were you married at any time during this pregnancy?
☐ **Yes** ☐ **No**
In the state of Minnesota, if you were married at any time during the pregnancy, your husband is legally the father of your baby and his name and place of birth will appear on the birth certificate. If you are unmarried, no information about the father will print on the birth certificate unless you and the father choose to complete a *Voluntary Recognition of Parentage* form to establish paternity.

If you are married and your husband is <u>not</u> the father of your baby, do you wish to complete a *Husband's Non-Paternity Statement* and a *Voluntary Recognition of Parentage?* Both forms are required to remove the husband's name and add the father.

☐ **Yes** ☐ **No**

If you are single and would like the father's name on your baby's birth record, you and the father can sign a *Voluntary Recognition of Parentage* form. This means the father accepts legal responsibility for this child.

☐ **Yes** we would like to sign a *Recognition of Parentage* form

☐ **No** the *Recognition of Parentage* form will not be done at this time. I understand there will be no father's information on my child's birth certificate.

If you are single, your baby's birth record is considered confidential <u>unless</u> you request the information to be public. A confidential record may be given to a parent or guardian of the child, to the child at age 16, or disclosed according to court order, but it is not available to grandparents, siblings or spouses.

☐ **Yes** change the birth record to a public record

☐ **No** leave the birth record as a confidential record

Both parents' demographics

Education – *check the box that best describes your highest level of school completed at the time of this baby's birth*

Mother	Father	
☐	☐	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)

Race – *check all that apply to you*

Mother	Father	
☐	☐	**White**
☐	☐	**Black or African American**
☐	☐	Somali
☐	☐	Liberian
☐	☐	Kenyan
☐	☐	Nigerian
☐	☐	Ethiopian
☐	☐	Ghanaian
☐	☐	Sudanese
☐	☐	Other African (specify) _____
☐	☐	**American Indian or Alaska Native** (specify name of enrolled/principal tribe) _____
☐	☐	**Asian**
☐	☐	Asian Indian
☐	☐	Chinese
☐	☐	Filipino
☐	☐	Japanese
☐	☐	Korean
☐	☐	Hmong
☐	☐	Cambodian
☐	☐	Laotian
☐	☐	Vietnamese
☐	☐	Other Asian (specify) _____
☐	☐	**Pacific Islander**
☐	☐	Native Hawaiian
☐	☐	Guamanian or Chamorro
☐	☐	Samoan
☐	☐	Other Pacific Islander (specify) _____
☐	☐	**Other Race (specify) _____**

Hispanic origin – *check all that apply*

Mother	Father	
☐	☐	No, not Spanish/Hispanic/Latina/Latino
☐	☐	Yes, Mexican, Mexican American
☐	☐	Yes, Puerto Rican
☐	☐	Yes, Cuban
☐	☐	Yes, other Spanish/Hispanic/Latina/Latino (e.g. Salvadoran, Dominican, Columbian) (specify) _____

Father

write current legal name below

first | **middle** | **last** | ☐ Jr ☐ Sr ☐ III ☐ ___

Date of birth	**Social Security Number**	**Place of birth - City, State (if US), Country**
/ / mm/dd/yyyy	/ / ☐ No Social Security Number	

Mailing address	☐ **use mother's mailing address**	**County of Residence?**

How to get a birth certificate for your baby

Birth certificates may be obtained by mail or fax from the Minnesota Department of Health (MDH) or in person from any Minnesota local registrar or county license center office. If you wish to order a Minnesota birth certificate by mail, please visit the MDH website at www.health.state.mn.us for order forms and more information.

Since MDH no longer handles in-person requests, you must go to a local registrar or county license center office to buy a birth certificate in person. It is no longer necessary to go to the registrar's office of the county where the birth took place. You may go to a registrar's office in any county in Minnesota. You will be asked to complete and sign an application stating that you have tangible interest (parents and guardians have tangible interest) in the certificate and show identification.

Birth certificates cost $26.

If you need to make a change or correction to the birth certificate, you may use the Parent Notice you will receive in the mail—as long as you make the change within 45 days. To make a Parent Notice correction, simply follow the directions on the Parent Notice and return it by the deadline printed on the form.

After 45 days, amendments cost $40 and you will be asked to complete an amendment form and provide documentation to prove the change is justified and accurate. See the MDH website for more information at www.health.state.mn.us.

Social Security Cards for babies

If you request it, the Minnesota Department of Health will electronically transmit birth data to the Social Security Administration as a service to you. Birth record changes or corrections are not communicated to SSA. If you make any changes to your baby's name, you must contact the Social Security Administration to change the Social Security Card. If you do not receive the Social Security card for any reason, contact Social Security at 1-800-772-1213. Or, purchase the birth certificate and bring it to the Social Security office. Social Security cards cannot be forwarded or re-sent for any reason.

You cannot obtain a birth certificate or a social security card from the hospital.

Facility Worksheet - Baby

Baby's birth date

Plurality (this gestation)

Birth order of this baby

Surrogacy? ☐ Yes ☐ No

Mother's last name, Medical Record Number

Birth attendant & title

Child's gender
☐ Male ☐ Female

Baby Transferred? If yes Where?

Baby's **Med record #**

Birth Weight
☐ Grams
☐ Pounds

Gestation

weeks

5 min Apgar

10 min Apgar

Mom's Hep B status
☐ Negative
☐ Positive ☐ Unknown

Hep B vaccine given to baby?
If yes, Date?

Hep B Immune Globulin (HBIG)given?
If yes, Date, Time

Abnormal conditions
- ☐ Assisted ventilation immediately after birth
- ☐ Assisted ventilation required >6 hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received for suspected neonatal sepsis
- ☐ Bacterial infection (blood) within 1-2 days of life
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture, peripheral nerve injury, soft tissue/solid organ hemorrhage with intervention)
- ☐ Anemia
- ☐ Other (specify) _____
- ☐ None of the above

Was baby breastfed or fed breast milk?
During stay? ☐ Yes ☐ No At discharge? ☐ Yes ☐ No

Is baby alive at the time of filing birth record?
☐ Yes ☐ No

Congenital anomalies
- ☐ Anencephaly
- ☐ Meningomyelocele/spina bifida
- ☐ Hypospadias
- ☐ Other urogenital anomalies _____
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Polydactyly/syndactyly/adactyly
- ☐ Club foot
- ☐ Other musculoskeletal/integumental anomalies_____
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Down syndrome Karyotype status _____
- ☐ Other suspected chromosomal disorder Karyotype status _____
- ☐ Other anomalies (specify) _____
- ☐ None of the above

Disposition
☐ Burial ☐ Donation
☐ Cremation ☐ Removal from state
☐ Hospital disposition ☐ Other

Funeral home
Name _____

City/town_____

☐ USA Other country _____

1. Cause of death – initiating cause/condition
☐ Maternal condition/disease _____
Complications of placenta cord or membranes
☐ PROM ☐ Abruption
☐ Placental insufficiency ☐ Prolapsed cord
☐ Chorioamnionitis
☐ Obstetrical or pregnancy complications _____
☐ Fetal anomaly _____
☐ Fetal injury _____
☐ Fetal infection _____
☐ Other fetal condition/disorder _____

Estimated time of Fetal death
- ☐ Dead at first assessment, no labor ongoing
- ☐ Dead at first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

Autopsy? ☐ Yes ☐ No

Histological placental exam? ☐ Yes ☐ No

Autopsy/Histology results used to determine cause of death?
☐ Yes ☐ No

2. Cause of death – contributing cause/condition
☐ Maternal condition/disease _____
Complications of placenta cord or membranes
☐ PROM ☐ Abruption
☐ Placental insufficiency ☐ Prolapsed cord
☐ Chorioamnionitis
☐ Obstetrical or pregnancy complications _____
☐ Fetal anomaly _____
☐ Fetal injury _____
☐ Fetal infection _____
☐ Other fetal condition/disorder _____

Facility Worksheet – Baby

INSTRUCTIONS

Baby's birthdate

Mother's last name, Medical Record Number

Plurality (this gestation)
The number of fetuses delivered live or dead at any time in the pregnancy, regardless of gestational age, or if fetuses were delivered at different dates during this pregnancy. Do not count "Reabsorbed" fetuses.

Birth order of this baby

If not a single birth, indicate the order born in the delivery.

If this is a single birth, leave blank.

Birth attendant & title *the individual physically present at delivery or immediately after who is responsible for the delivery. If someone delivers baby under supervision of an obstetrician who is present in the room, that obstetrician is the attendant.*

Child's gender
Enter whether the infant is male, female or unknown

Baby Transferred? *If baby was transferred more than once, indicate name of first facility*

Baby's Med record #

Birth Weight *enter the weight in grams. But DO NOT convert pounds to grams if gram weight is unavailable.*

Gestation *based on the birth attendant's final estimate of gestation, or early prenatal ultrasound, not the neonatal exam*

5 min Apgar
Enter the Apgar score at 5 minutes of life

10 min Apgar
If Apgar score at 5 minutes is less than 6, enter a 10 min Apgar

Mom's Hep B status
Enter the mother's hepatitis B surface antigen status

Hep B vaccine given to baby?
If baby received birth dose of Hep B vaccine, enter date

Hep B Immune Globulin (HBIG)given?
If baby received HBIG, enter Date, Time

Abnormal conditions

Assisted ventilation immediate *given manual breaths with bag & mask or bag & endotracheal tube NOT free flow O_2 or laryngoscopy for meconium aspiration*

Assisted ventilation >6 hours *includes conventional, High frequency and or continuous positive pressure(CPAP)*

NICU admission *to facility or unit staffed & equipped to provide continuous mechanical ventilatory support at any time during hospital stay*

Surfactant therapy *for treatment of respiratory distress*

Antibiotics for suspected neonatal sepsis do *NOT include antibiotics given for any other reason.*

Confirmed bacterial infection (blood) within 1-2 days of life

Seizure or neurologic dysfunction *excludes lethargy or hypotonia in the absence of other neurologic findings*

Birth injury (skeletal fracture, peripheral nerve injury, soft tissue/solid organ hemorrhage with intervention) *Present or immediately following delivery*.

Anemia (HCT <39 / HGB <13)

Was baby breastfed or fed breast milk?

Refers to the action of breast-feeding or pumping (expressing) milk – NOT the intention to breast-feed

Is baby alive at the time of filing birth record?

Indicate only the KNOWN status – if baby was transferred and the status is known, indicate the known status.

Congenital anomalies

Anencephaly *partial or complete absence of brain and skull*

Meningomyelocele/spina bifida *herniation of meninges and/or spinal cord tissue through bony defect of spine closure – include open & closed lesions*

Hypospadias *incomplete closure of male urethra*

Other urogenital anomalies

Cyanotic congenital heart disease

Congenital diaphragmatic hernia

Omphalocele a *defect (covered by membrane) in anterior abdominal wall, with herniation of abdominal organs into umbilical stalk. NOT umbilical hernia.*

Gastroschisis abnormality of anterior abdominal wall, lateral to umbilicus with herniation into amniotic cavity.

Limb reduction defect (exclude amputation & dwarfing) absence *of all or a portion of an extremity, secondary to failure to develop.*

Polydactyly/syndactyly/adactyly *more than 5, fused or absence of fingers or toes*

Club foot *congenital talipes equinovarus (CTEV)*

Other musculoskeletal/integumental anomalies

Cleft lip *incomplete closure of lip*

Cleft palate *incomplete fusion of palate*

Down syndrome *Trisomy 21 with Karyotype status (pending/confirmed*)

Suspected chromosomal disorder *indicate Karyotype status*

Facility Worksheet - Mother's Medical

Baby's birth date

Mother's last name, Medical Record Number

Did mother get WIC food during this pregnancy?
☐ Yes ☐ No *If yes* - Month WIC began?

Were cigarettes smoked 3 months before or during pregnancy? ☐ Yes ☐ No *If yes* – number of cigarettes or packs per day
☐ *Cigarettes* ☐ *Packs* ___ 3 mo before ___ First trimester ___ Second trimester ___ Third trimester

Prenatal care? ☐ Yes ☐ No	**Date of first visit**	**Date of last visit**	**Total number of visits**	**Month of pregnancy that care began**

Mother's height	**Pre-pregnancy weight**	**Delivery weight**	**Date of LMP**

# of prev. live births now living	**# of prev. live births now dead**	**Date of last live birth**	**# of losses or terminations**	**Date of last loss or termination**

Risk factors for this pregnancy
- ☐ Diabetes pre-pregnancy
- ☐ Diabetes gestational
- ☐ Hypertension pre-pregnancy (chronic)
- ☐ Hypertension gestational (PIH, preeclampsia)
- ☐ Eclampsia
- ☐ Pregnancy resulted from infertility treatments
  - ☐ fertility drugs, artificial / intrauterine insemination
  - ☐ assisted reproductive technology (IVF) (GIFT)
- ☐ Anemia (HCT<30 / HGB <10)
- ☐ Previous preterm birth
- ☐ Other prev poor outcome (include perinatal death, SGA, IUGR)
- ☐ Previous cesarean birth
- ☐ Other risk factors _____
- ☐ None of the above

Onset of labor
- ☐ Premature rupture of membranes
- ☐ Precipitous labor
- ☐ Prolonged labor
- ☐ None of the above

Characteristics of labor and delivery
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation
- ☐ Antibiotics received by mother during labor
- ☐ Maternal fever (>38C) / Chorioamnionitis during labor
- ☐ Moderate/heavy meconium staining in amniotic fluid
- ☐ Fetal intolerance of labor requiring intervention
- ☐ Epidural or spinal anesthesia during labor
- ☐ Other Specify _____
- ☐ None of the above

Toxicology tests performed on mother or baby? – Result?

Time of Birth

Principal source of payment
- ☐ Private insurance ☐ Medicaid
- ☐ Champus/tricare/other government ☐ Other
- ☐ Self pay

Infections present and or treated this pregnancy
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Group B streptococcus
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Other infection (specify) _____
- ☐ None of the above
- ☐ *Cytomegalovirus
- ☐ *Listeria .
- ☐ *Toxoplasmosis .
- ☐ *Parvovirus .

Method of birth
- ☐ Forceps attempted Successful? ☐ Yes ☐ No
- ☐ Vacuum attempted Successful? ☐ Yes ☐ No

Fetal presentation at birth?
☐ Cephalic ☐ Breech ☐ Other

Final route and method of birth
- ☐ Vaginal/spontaneous
- ☐ Vaginal/forceps
- ☐ Vaginal/vacuum
- ☐ Cesarean was trial of labor attempted? ☐ Yes ☐ No
- ☐ VBAC (vaginal birth after cesarean)
- ☐ *Hysterotomy/Hysterectomy

Prenatal obstetric procedures
- ☐ Cervical Cerclage
- ☐ Tocolysis
- ☐ External cephalic version *Successful?* Yes No
- ☐ None of the above

Mother transferred prior to birth ☐ Yes ☐ No
If yes, Where from?

Maternal morbidity
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Cord prolapse
- ☐ Seizure during labor
- ☐ Placental abruption
- ☐ Placenta previa
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following birth
- ☐ Other (specify) _____
- ☐ None of the above

Facility Worksheet - Mother's Medical

INSTRUCTIONS

Baby's birthdate

Did mother get WIC? *List month of pregnancy that WIC began <this is also on mother's worksheet>*

Were cigarettes smoked 3 months before or during pregnancy? *If yes – number of cigarettes or packs per day 3 mo before and in each trimester <this is also on mother's worksheet>*

Prenatal care?	**Date of first visit**	**Date of last visit**	**Total visits**	**Month care began**
Mother's height	**Pre-pregnancy weight**	**Delivery weight**	**Date of LMP**	
# live births now living	**# live births / dead**	**Date of last live birth**	**# of losses**	**Date of last loss or termination**

Parity *Do not include this child. Do include any previous births in this delivery if multiple gestation.*

Risk factors for this pregnancy

Diabetes *pre-pregnancy*
Diabetes *diagnosed during pregnancy*
Hypertension *diagnosed pre-pregnancy*
Hypertension (PIH, preeclampsia) *diagnosed during pregnancy may include proteinuria without seizures or coma and edema*
Eclampsia *pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include edema.*
Pregnancy resulted from infertility treatments *fertility drugs, artificial or intrauterine insemination, assisted reproductive technology (IVF) (GIFT)*
Anemia (HCT<30 / HGB <10)
Previous preterm birth *less than 37 wks gestation*
Other prev poor outcome (include perinatal death, SGA, IUGR)
Previous cesarean birth

Toxicology tests

(appears on baby's medical sheet also) *Any tests performed on mother or baby to check for recreational drug or un-prescribed medication use.* If YES*, indicate as: "positive (or pending) for (indicate name of drug or drugs")*

Onset of labor

Premature rupture of membranes *>12 before onset of labor*
Precipitous labor *(<3 hours)*
Prolonged labor *(>20 hours)*

Characteristics of labor and delivery

Induction *initiating contractions by medical and/or surgical means*
Augmentation *labor stimulation by drug or manipulative technique*
Non-vertex *face, breech, shoulder, brow, transverse in active labor*
Steroids *betamethasone, dexamethasone or hydrocortisone specifically given to accelerate fetal lung maturation. Excludes anti inflammatory treatment.*
Antibiotics *given between onset of labor and delivery*
Fever/Chorioamnionitis *clinical diagnosis of chorioamnionitis during labor. Any maternal temperature ≥38ºC*
Meconium *enough to cause staining of otherwise clear fluid*
Fetal intolerance with intervention *maternal: position change, O2, IV fluids, or amnioinfusion, support of maternal bld pressure, admin of uterine relaxing agents, or fetal: scalp PH, scalp stimulation, acoustic stimulation or any* operative delivery *intervention to shorten time of delivery (forceps, vacuum, or C Section*
Epidural or spinal anesthesia *during labor*

Principal source of payment

Time of Birth

Method of birth

Forceps *was forceps attempt successful?*
Vacuum *was vacuum attempt successful?*

Fetal presentation at birth?
Cephalic *include OA, OP* **Breech** *include complete, frank, footlong breech*

Final route and method of birth
Vaginal/spontaneous **forceps** **vacuum**
Cesarean trial of labor? *Indicate if labor was allowed, augmented or induced with plans for a vaginal delivery*
VBAC *(vaginal birth after cesarean)*
Hysterotomy *uterine incision extending into the uterine cavity*
Hysterectomy *surgical removal of the uterus*

Infections present and or treated this pregnancy

Indicate if any of the following infections were diagnosed or treated during the pregnancy

Chlamydia	Hepatitis B
Genital herpes	Hepatitis C
Gonorrhea	HIV positive
Group B streptococcus	Syphilis

Other infection (specify) _____

Prenatal obstetric procedures

Cerclage *banding or suture of cervix to prevent/treat passive dilatation*
Tocolysis *administration of any agent ($MgSO_4$, Terbutaline, Brethine, Indocin) with the intent to inhibit preterm uterine contractions to extend the length of pregnancy.*
Version *external manipulation to convert baby to vertex positioning.*

Mother transferred prior to birth

Transfers include hospital to hospital, birth facility to hospital. Do not include unplanned *homebirth transfers to hospital.*
If a planned homebirth transfers to the hospital for any reason, please indicate "planned homebirth" in the notes section of MR&C.

Maternal morbidity

Transfusion *infusion of whole blood or packed red blood cells*
3rd º Laceration *extends through perineal skin, vaginal mucosa, perineal body and anal sphincter* **4th º** *all of the above with extension through rectal mucosa*
Ruptured Uterus *tearing of uterine wall*
Unplanned Hysterectomy *ANY unplanned hysterectomy*
Admission to ICU *Any admission, planned or unplanned of the mother to a facility or unit providing intensive care*
Unplanned OR procedure *excludes postpartum tubal ligation*