VERMONT DEPARTMENT OF HEALTH

PARENT'S WORKSHEET FOR CHILD'S BIRTH CERTIFICATE

Please answer completely the Child, Mother, and Father or Parent sections. Social security numbers are required by Federal law, 42 USC 405(c)(2), and by VT law, 18 VSA §5071(b). Only information identifying the child and the parents will be recorded on the child's birth certificate and filed with the Town Clerk and the VT Dept. of Health. Social security numbers will not appear on the birth certificate. Under the authority of the Privacy Act, the information collected under the EAB process will be used by the SSA for various programs operated by the SSA, including the release of information to state and federal agencies for the verification of citizenship. The Department is providing the link to the SSA privacy notice: http://www.ssa.gov/foia/bluebook/60-0058.htm . Also, the VT Office of Child Support may use social security numbers only for child support enforcement. Other personal and medical information will become part of the confidential statistical file maintained by the VT Dept. of Health, and will not appear on your child's birth certificate.

CHILD'S INFORMATION

1. CHILD'S NAME
First
Middle
Last Suffix (Sr., Jr., II, III, etc.)

2. DATE OF BIRTH (MM/DD/YYYY)
/ /

3. TIME OF BIRTH
_____AM _____PM

4. SEX
☐ Male ☐ Female

MOTHER'S INFORMATION

5. MOTHER'S CURRENT LEGAL NAME
First
Middle
Last Suffix

6. DATE OF BIRTH (MM/DD/YYYY)
/ /

7a. BIRTHPLACE (State, Territory, or Foreign Country)

7b. IF CANADA, include Province

8. MOTHER'S SOCIAL SECURITY NUMBER

9. MOTHER'S BIRTH NAME

10. DO YOU WANT A SOCIAL SECURITY CARD AUTOMATICALLY ISSUED FOR YOUR CHILD? ☐ Yes ☐ No

11. SAFE AT HOME PARTICIPANT? ☐ Yes ☐ No
If Yes, authorization number:

12a. MOTHER MARRIED AT TIME OF BIRTH, CONCEPTION, OR ANY TIME BETWEEN?
☐ Yes (Complete FATHER'S OR PARENT'S INFORMATION)
☐ No

12b. IF NO: MOTHER PARTY TO A VT CIVIL UNION?
☐ Yes (Complete PARENT'S INFORMATION) ☐ No

12c. HAS A VOLUNTARY ACKNOWLEDGEMENT OF PATERNITY BEEN SIGNED?
☐ Yes (Complete FATHER'S INFORMATION) ☐ No

13a. RESIDENCE: NUMBER AND STREET

13b. CITY OR TOWN

13c. STATE OR FOREIGN COUNTRY (IF CANADA, include Province)

13d. ZIP CODE

14. TELEPHONE NUMBER
( ) -

15. MOTHER'S MAILING ADDRESS: ☐ Same as residence, OR:
Number & Street: City or Town: State: Zip Code:

16. MOTHER'S EDUCATION
(Check the box that best describes highest degree or level of school completed at the time of delivery.)

- ☐ 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)

17. MOTHER OF HISPANIC ORIGIN?
(Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina.)

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (Specify): _____

18. MOTHER'S RACE
(Check ***one or more races*** to indicate what the mother considers herself to be.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the 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): _____

19. MOTHER'S PREPREGNANCY WEIGHT (Pounds)

20. MOTHER'S HEIGHT
Feet: Inches:

21. DID MOTHER GET WIC FOOD FOR HERSELF DURING PREGNANCY?
☐ Yes ☐ No

22. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

AVERAGE NUMBER OF CIGARETTES OR PACKS PER DAY: IF NONE, ENTER "0" FOR EACH TIME PERIOD

	# of cigarettes	# packs		# of cigarettes	# packs
Three Months Before Pregnancy	_____ OR	_____	Second Three Months Of Pregnancy	_____ OR	_____
First Three Months Of Pregnancy	_____ OR	_____	Third Trimester Of Pregnancy	_____ OR	_____

FATHER'S OR PARENT'S INFORMATION

23. FATHER'S OR PARENT'S CURRENT LEGAL NAME

First

Middle

Last Suffix

24. DATE OF BIRTH (MM/DD/YYYY)

/ /

25. SEX

☐ Male ☐ Female

26a. BIRTHPLACE (State, Territory, or Foreign Country)

26b. IF CANADA, include Province

27. FATHER'S OR PARENT'S SOCIAL SECURITY NUMBER

28. FATHER'S OR PARENT'S MAILING ADDRESS:

Number & Street: City or Town: State: Zip Code:

29. FATHER'S OR PARENT'S EDUCATION

(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

- ☐ 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)

30. FATHER OR PARENT OF HISPANIC ORIGIN?

(Check the box that best describes whether the father/parent is Spanish/Hispanic/Latino/Latina. Check the "No" box if father/parent is not Spanish/Hispanic/Latino/Latina.)

- ☐ No, not Spanish/Hispanic/Latino/Latina
- ☐ Yes, Mexican, Mexican American, Chicano/Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino/Latina (Specify): _____

31. FATHER'S OR PARENT'S RACE (Check ***one or more races*** to indicate what the father/parent considers himself/herself to be.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the 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): _____

OPTIONAL SIGNATURE:

I agree that the above information is accurate: Date:

If <u>not</u> baby's mother; relationship: ☐ Baby's father or parent ☐ Other relative ☐ Hospital employee ☐ Other, please specify:

VERMONT DEPARTMENT OF HEALTH

FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE

MOTHER'S LAST NAME:

FACILITY INFORMATION

32a. PLACE WHERE BIRTH OCCURRED
- ☐ Hospital
- ☐ Clinic/Doctor's Office
- ☐ Other (Specify): _____
- ☐ En route
- ☐ Freestanding Birth Center
- ☐ Home Was it planned? ☐ Yes ☐ No

32b. NAME OF FACILITY (If not a facility, enter street address and number)

33. CITY, TOWN, OR LOCATION OF BIRTH

NEWBORN'S STATISTICAL INFORMATION

34. NEWBORN MEDICAL RECORD NUMBER

35. OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)

36. BIRTH WEIGHT lbs ozs **OR** Grams

37. APGAR SCORE AT 5 MINUTES

IF SCORE IS LESS THAN 6, SCORE AT 10 MINUTES

38. PLURALITY – Single, Twin, Triplet, etc. (Specify)

39. IF NOT SINGLE BIRTH – Born 1st, 2nd, 3rd, etc. (Specify)

40. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No
If yes, NAME OF FACILITY infant was transferred to:

41. IS INFANT LIVING AT THE TIME OF REPORT? ☐ Yes ☐ No

42. IS INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

MOTHER'S STATISTICAL INFORMATION

43. MOTHER'S MEDICAL RECORD NUMBER

44. MOTHER'S WEIGHT AT DELIVERY (Pounds)

45. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No
If yes, NAME OF FACILITY mother was transferred from:

46. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
- ☐ Medicaid
- ☐ Private Insurance
- ☐ Self-pay
- ☐ Other (Specify): _____

47. DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)
/ /

48a. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)
Number Now Living _____ ☐ None
Number Now Dead _____ ☐ None

48b. DATE OF LAST LIVE BIRTH (Do not include this child) (MM/YYYY)
/

49a. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous or induced losses or ectopic pregnancies)
Number of Other Outcomes_____ ☐ None

49b. DATE OF LAST OTHER PREGNANCY OUTCOME (MM/YYYY)
/

50a. DATE OF FIRST PRENATAL CARE VISIT (MM/DD/YYYY)
/ / ☐ No Prenatal Care

50b. DATE OF LAST PRENATAL CARE VISIT (MM/DD/YYYY)
/ /

51. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
(If none, enter '0') _____

52. PRENATAL CARE PROVIDER'S NAME
First Middle Last Suffix

MEDICAL AND HEALTH INFORMATION

53. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm births

☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment – If yes, check all that apply:
- ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro fertilization, gamete intrafallopian transfer)

☐ Mother had a previous cesarean delivery? If yes, how many_____

☐ None of the above

54. ONSET OF LABOR (Check all that apply)
- ☐ Premature rupture of the membranes (prolonged, ≥ 12hrs)
- ☐ Precipitous Labor (< 3hrs)
- ☐ Prolonged Labor (≥ 20hrs)
- ☐ None of the above

56a. GROUP B STREP STATUS
- ☐ Negative
- ☐ Positive
- ☐ Not performed

56b. GROUP B STREP PROPHYLAXIS STATUS
- ☐ No treatment
- ☐ Greater than 4 hours before delivery
- ☐ Less than or equal to 4 hours before delivery

55. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None of the above

57. CHARACTERISTICS OF LABOR AND DELIVERY
(Check all that apply)

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

58. METHOD OF DELIVERY

Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

Final route and method of delivery (Check One)
Vaginal:
☐ Spontaneous ☐ Forceps ☐ Vacuum
☐ Cesarean:
If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

Fetal presentation at birth
- ☐ Cephalic
- ☐ Breech
- ☐ Other

59. OBSTETRIC PROCEDURES
(Check all that apply)

- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ Successful External cephalic version
- ☐ Failed External cephalic version
- ☐ None of the above

60. CONGENITAL ANOMALIES OF THE NEWBORN (Evident at delivery and require intervention)
(Check all that apply)

- ☐ Anencephaly
- ☐ Meningomyelocele / Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft Lip with or without Cleft Palate
- ☐ Cleft Palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the anomalies listed above

61. 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, soft tissue or solid organ hemorrhage which requires intervention)
- ☐ None of the above

62. MATERNAL MORBIDITY (complications associated with labor and delivery)
(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

ATTENDANT AND CERTIFIER INFORMATION

63a. ATTENDANT – Name and Title

_____ ____ _____
First Name MI Last Name

☐ MD ☐ DO ☐ CNM/CM ☐ Licensed Midwife ☐ Hospital Administrator
☐ Other (Specify): _____

63b. LICENSE NUMBER:

64a. CERTIFIER – Name and Title

_____ ____ _____
First Name MI Last Name

☐ MD ☐ DO ☐ CNM/CM ☐ Licensed Midwife ☐ Hospital Administrator
☐ Other (Specify): _____

64b. DATE CERTIFIED (MM/DD/YYYY):

/ /