

Mother's Worksheet for Child's Birth Certificate

FOR HOSPITAL USE ONLY:

MOTHER MR# _____ NEWBORN MR# _____
 MEDICAID # _____ DELIVERING DR _____ RM # _____

The information you provide on this worksheet is used to create your child's birth certificate. The birth certificate is a legal document used to prove your child's age, citizenship and parentage. Your child will use the birth certificate throughout his/her life. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Please **PRINT** your responses carefully and accurately as errors are difficult and expensive to correct.

CHILD'S PLACE OF BIRTH

Name of Hospital or Location	Address	State
<input type="text"/>	<input type="text"/>	<input type="text"/>
County	City	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

CHILD'S INFORMATION

Time of Birth	Date of Birth	Plurality (please circle one)
<input type="text"/>	<input type="text"/>	Am / Pm <input type="text"/>
Single / Twin / Triplets / Quadruplets / Quintuplets		
Birth Order (please circle one)	Number of Infants Born Alive at this Birth? (please circle one)	
First / Second / Third / Fourth / Fifth	One / Two / Three / Four / Five	

MOTHER'S CURRENT LEGAL NAME

First Name	Middle Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CHILD'S LEGAL NAME

First Name	Middle Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MOTHER'S RESIDENCE ADDRESS

Residence Address	Apartment Number	State/Foreign Country	County
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City/Town/Location	Zip Code / Extension	Inside City Limits?	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MOTHER'S MAILING ADDRESS (If same as residence address, LEAVE THIS SECTION BLANK)

Mailing Address	Apartment Number	State/Foreign Country
<input type="text"/>	<input type="text"/>	<input type="text"/>
City/Town/Location	Zip Code / Extension	Inside City Limits?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

MOTHER'S INFORMATION

Date of Birth

Place of Birth (State/Foreign Country/Territory)

Social Security

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Apply for Baby's Social Security?

Did Mother Give up Rights to the Child?

Date Rights Given Up?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Occupation

Type of Business

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Mother's Education

- 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)

Is Mother of Hispanic Origin?

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

What is Mother's Race?

- | | |
|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other Asian _____ |
| <input type="checkbox"/> American Indian/Alaska Native
(Name of the enrolled or principal tribe)
_____ | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Pacific Islander
Specify _____ |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Unknown |

MOTHER'S HEALTH INFORMATION

Did you receive WIC for this Birth?

Height

Weight Before Pregnancy

Weight At Delivery

<input type="checkbox"/> Yes <input type="checkbox"/> No			
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How many cigarettes did you smoke before and during pregnancy?

Three Months Before	Cigs/Day: _____	Packs/Day: _____	First Three Months	Cigs/Day: _____	Packs/Day: _____
Second Three Months	Cigs/Day: _____	Packs/Day: _____	Third Trimester	Cigs/Day: _____	Packs/Day: _____

MOTHER'S MARITAL STATUS (Please read carefully)

- If you are married, your husband may be listed as the father on the birth certificate, or the information may be left blank.
- If you are not married, the father's name may be listed on the birth certificate only if both parents complete an Acknowledgment of Paternity.
- If you are or have been married to someone other than the biological father of this child, or have been married to someone other than the biological father within 300 days before this child's birth, the Acknowledgment of Paternity must also include a Denial of Paternity from your husband or former husband to allow the biological father's information to be listed on the birth certificate.

Yes, Currently Married

Yes, Never Married

Yes, Divorced

Yes, Widowed

Yes, Married – (no paternity information on birth certificate)

Have you been married to someone other than the biological father in the 300 days before the child's birth? Yes No

Do you want to complete an Acknowledgement of Paternity? Yes No

MOTHER'S NAME PRIOR TO HER FIRST MARRIAGE

First Name

Middle Name

Last Name

Suffix

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FATHER'S INFORMATION (Biological father)

Legal First Name	Middle Name	Last Name	Suffix

Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security

Occupation	Type of Business

Father's Education <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th – 12 th grade, no diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	Is Father of Hispanic Origin? <input type="checkbox"/> No, not Spanish / Hispanic / Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish / Hispanic / Latino Specify _____	What is Father's Race? <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander Specify _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
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Has Paternity – Genetic Testing Been Done? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mailing Address	Apartment Number

State/Foreign Country/Territory	City/Town/Location	Zip Code / Extension

PRESUMED FATHER'S INFORMATION (Complete ONLY if applicable)

Date of Birth	Social Security

First Name	Middle Name	Last Name	Suffix

Mailing Address	Apartment Number	State/Foreign Country/Territory

City/Town/Location	Zip Code Extension

MOTHER'S MEDICAID INFORMATION (Complete ONLY if applicable)

Mother's Medicaid Name	Mother's Medicaid Number

IMMTRAC REGISTRY

Do you consent for your baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers? <input type="checkbox"/> Yes <input type="checkbox"/> No

Congratulations on the birth of your new Little Texan!

Texas Vital Statistics would like to take this opportunity to answer some most commonly asked questions about birth certificates in Texas. . .

“How do I get a copy of my baby’s birth certificate?”

You can request and purchase a certified copy of your child’s birth certificate from the local registrar’s office located in the city or county where the birth occurred, or from the Texas Vital Statistic office located in Austin, Texas.

A *Certified Birth Certificate* is a permanent legal document filed in the State of Texas that establishes your child’s identity and is used to apply for medical or government services, passports, school admission, etc.

“When will I receive my baby’s social security card?”

If you answered “Yes” to the question, “Apply for baby’s social security number?”, the birth information will be forwarded to the Social Security Administration as soon as the Texas Vital Statistic office receives the data from the hospital. The Social Security Administration then requires 2-3 weeks to process the information. A social security card will be mailed to the mother’s mailing address as provided in this worksheet. The entire process usually takes **4-6 weeks** to complete.

“When will I receive my baby’s Medicaid number?”

If you provided an answer for the questions “Mother’s Medicaid Name?” and “Mother’s Medicaid Number?”, the birth information will be forwarded to the Medicaid office as soon as the Texas Vital Statistic office receives the data from the hospital. Medicaid then requires 2-3 weeks to process the information. An Infant Medicaid card will be mailed to the mother’s mailing address as provided in this worksheet. The entire process usually takes **4-6 weeks** to complete.

Medical Data Worksheet for Child's Birth Certificate

This form to be completed by hospital staff. This data will be used to populate the medical data portion of the birth certificate for the newborn. The medical data is required to be reported within five days of the birth. **[HSC §192.003]**

PATIENT REFERENCE:

MOTHER MR# _____	NEWBORN MR# _____
MOTHER'S NAME _____	NEWBORN NAME _____
MEDICAID# _____	DOB _____
DELIVERING DR _____	DATE AOP SENT _____
MOTHER TRANSFERRED _____	SOURCE OF PAYMENT FOR DELIVERY _____

Born at Facility
 Born En Route
 Foundling
 Home Birth

Prenatal Care Yes No Unknown

Date of First Visit ____/____/____

Date of Last Visit ____/____/____

Total Number of Prenatal Visits for this Pregnancy: _____

Date Last Normal Menses Began ____/____/____

Source of Prenatal Care (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Midwife |
| <input type="checkbox"/> Hospital Clinic | <input type="checkbox"/> Other, Specify _____ |
| <input type="checkbox"/> Public Health Clinic | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Private Physician | |

Pregnancy History

Live births now living (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "0".): _____

Live births now dead (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "0".): _____

Date of last live birth: ____/____/____
MM **YYYY**

Number of other pregnancy outcomes (Include fetal losses of any gestational age. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy. If **none** enter "0".): _____

Date of last other pregnancy outcome: ____/____/____
MM **YYYY**

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 birth
- Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- Pregnancy resulted from infertility treatment
 - Fertility-enhancing drugs, artificial insemination or intrauterine insemination
 - Assisted reproductive technology
- Mother had a previous cesarean delivery
If yes, how many? _____
- Antiretrovirals administered during pregnancy or at delivery
- None of the above

Infections Present and/or Treated During Pregnancy (check all that apply)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> None of the above |

HIV Test

- HIV test done Prenatally Yes No Unknown
- HIV test done at Delivery Yes No Unknown

Obstetric Procedures (check all that apply)

- Cervical cerclage
 Tocolysis

External cephalic version

- Successful Failed
 None of the above

Characteristics of Labor & Delivery

(check all that apply)

- Induction of labor
 Augmentation of labor
 Non-vertex presentation
 Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery
 Antibiotics received by mother during labor
 Chorioamnionitis or maternal temperature ≥ 38 degrees C or 100.4 degrees F
 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 assessments, or operative delivery
 Epidural or spinal anesthesia during labor
 None of the above

Maternal Morbidity – Complications associated with Labor & 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

Was Infant Transferred within 24 hours of Delivery?

- No Yes, Specify Facility _____

Is Infant Living at Time of Report?

- Yes No

Is Infant Being Breastfed at Discharge?

- Yes No

Hepatitis B Immunization given?

- Yes No

Onset of Labor (check all that apply)

- Premature Rupture of the Membranes [prolonged ≥ 12 hours]
 Precipitous Labor [< 3 hours]
 Prolonged Labor [≥ 20 hours]
 None of the above

Method of Delivery

Was delivery with forceps attempted but unsuccessful?

- Yes No Unknown

Was delivery with vacuum extraction attempted but unsuccessful?

- Yes No Unknown

Fetal presentation at birth

- Cephalic Breech Other, _____

Final route and method of delivery

- Vagina/Spontaneous Vagina/Forceps Vagina/Vacuum

If cesarean, was a trial of labor attempted?

 Cesarean

- Yes No Unknown

Child's Health Information**Birth Weight** _____ Grams, or _____ LB. _____ OZ.**Obstetric Estimate of Gestation (completed weeks):** _____**Child's Sex:** Male Female Not yet determined**Apgar Score:** at 5 min: _____; (if less than 6) at 10 min: _____**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

Congenital Anomalies of the Newborn (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Anencephaly | <input type="checkbox"/> Cleft palate alone |
| <input type="checkbox"/> Meningomyelocele/Spina bifida | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> Cyanotic congenital heart disease | <input type="checkbox"/> Karyotype confirmed |
| <input type="checkbox"/> Congenital diaphragmatic hernia | <input type="checkbox"/> Karyotype pending |
| <input type="checkbox"/> Omphalocele | <input type="checkbox"/> Suspected chromosomal disorder |
| <input type="checkbox"/> Gastroschisis | <input type="checkbox"/> Karyotype confirmed |
| <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) | <input type="checkbox"/> Karyotype pending |
| <input type="checkbox"/> Cleft lip with or without Cleft palate | <input type="checkbox"/> Hypospadias |
| | <input type="checkbox"/> None of the above |