

**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.

<b>CHILD'S INFORMATION</b>			
<b>1. CHILD'S NAME</b> First _____		<b>2. DATE OF BIRTH</b> (MM/DD/YYYY) / /	
Middle _____		<b>3. TIME OF BIRTH</b> _____ AM _____ PM	
Last _____ Suffix (Sr., Jr., II, III, etc.) _____		<b>4. SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>MOTHER'S INFORMATION</b>			
<b>5. MOTHER'S CURRENT LEGAL NAME</b> First _____		<b>6. DATE OF BIRTH</b> (MM/DD/YYYY) / /	
Middle _____		<b>7a. BIRTHPLACE</b> (State, Territory, or Foreign Country)	<b>7b. IF CANADA</b> , include Province
Last _____ Suffix _____		<b>8. MOTHER'S SOCIAL SECURITY NUMBER</b>	
<b>9. MOTHER'S BIRTH NAME</b>		<b>10. DO YOU WANT A SOCIAL SECURITY CARD AUTOMATICALLY ISSUED FOR YOUR CHILD?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>11. SAFE AT HOME PARTICIPANT?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, authorization number: _____	
<b>12a. MOTHER MARRIED AT TIME OF BIRTH, CONCEPTION, OR ANY TIME BETWEEN?</b> <input type="checkbox"/> Yes (Complete FATHER'S OR PARENT'S INFORMATION) <input type="checkbox"/> No		<b>12b. IF NO: MOTHER PARTY TO A VT CIVIL UNION?</b> <input type="checkbox"/> Yes (Complete PARENT'S INFORMATION) <input type="checkbox"/> No	
		<b>12c. HAS A VOLUNTARY ACKNOWLEDGEMENT OF PATERNITY BEEN SIGNED?</b> <input type="checkbox"/> Yes (Complete FATHER'S INFORMATION) <input type="checkbox"/> No	
<b>13a. RESIDENCE: NUMBER AND STREET</b>		<b>13b. CITY OR TOWN</b>	
<b>13c. STATE OR FOREIGN COUNTRY</b> (IF CANADA, include Province)		<b>13d. ZIP CODE</b>	<b>14. TELEPHONE NUMBER</b> ( ) -
<b>15. MOTHER'S MAILING ADDRESS:</b> <input type="checkbox"/> Same as residence, OR: Number & Street: _____ City or Town: _____ State: _____ Zip Code: _____			
<b>16. MOTHER'S EDUCATION</b> (Check the box that best describes highest degree or level of school completed at the time of delivery.) <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> 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)		<b>17. MOTHER OF HISPANIC ORIGIN?</b> (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina.) <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify): _____	
		<b>18. MOTHER'S RACE</b> (Check <b>one or more races</b> to indicate what the mother considers herself to be.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or 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 (Specify): _____ <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 (Specify): _____	
<b>19. MOTHER'S PREPREGNANCY WEIGHT</b> (Pounds)		<b>22. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY</b>	
<b>20. MOTHER'S HEIGHT</b> Feet: _____ Inches: _____		AVERAGE NUMBER OF CIGARETTES OR PACKS <u>PER DAY</u> : IF NONE, ENTER "0" FOR EACH TIME PERIOD	
<b>21. DID MOTHER GET WIC FOOD FOR HERSELF DURING PREGNANCY?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		# 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**

<b>23. FATHER'S OR PARENT'S CURRENT LEGAL NAME</b>		<b>24. DATE OF BIRTH</b> (MM/DD/YYYY) / /	<b>25. SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
First	<b>26a. BIRTHPLACE</b> (State, Territory, or Foreign Country)		<b>26b. IF CANADA</b> , include Province
Middle	<b>27. FATHER'S OR PARENT'S SOCIAL SECURITY NUMBER</b>		
Last	Suffix		
<b>28. FATHER'S OR PARENT'S MAILING ADDRESS:</b>			
Number & Street:		City or Town:	State: Zip Code:
<b>29. FATHER'S OR PARENT'S EDUCATION</b> (Check the box that best describes the highest degree or level of school completed at the time of delivery.)	<b>30. FATHER OR PARENT OF HISPANIC ORIGIN?</b> (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.)	<b>31. FATHER'S OR PARENT'S RACE</b> (Check <i>one or more races</i> to indicate what the father/parent considers himself/herself to be.)	
<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> 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)	<input type="checkbox"/> No, not Spanish/Hispanic/Latino/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino/Latina (Specify): _____	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or 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 (Specify): _____ <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 (Specify): _____	

**OPTIONAL SIGNATURE:**

I agree that the above information is accurate:

Date:

**if not 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  En route  
 Clinic/Doctor's Office  Freestanding Birth Center  
 Other (Specify): \_\_\_\_\_  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 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 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

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

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

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

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

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

55. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)  
 Gonorrhea  
 Syphilis  
 Chlamydia  
 Hepatitis B  
 Hepatitis C  
 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

