

Worksheet for Out-of-Hospital Births

Please Bring This Completed Form to Register Your Child's Out-of-Hospital Birth

Child's Information	First Name	Middle	Last
	Sex	This Birth Specify 1=Single, 2=Twin, 3=Triplet, Etc.	
	Date of Birth	Time of Birth ☐ a.m. ☐ p.m.	
	Place of Birth	Street Address	
	City	County	Zip
Father/ Parent's Information	First Name	Middle	Last (Birth)
	State of Birth	Date of Birth	
Mother/ Parent's Information	First Name	Middle	Last (Birth)
	State of Birth	Date of Birth	

The Following is Confidential Information and Will be Used for Public Health Purposes Only

Father/ Parent's Information	Race (list up to 3)		Hispanic: ☐ Yes ☐ No		Date Last Worked
	See Attached Race/Ethnicity Worksheet		Specify: _____		
	Usual Occupation	Usual Kind of Business or Industry	Education – Years Completed	Social Security Number	
Mother/ Parent's Information	Race (list up to 3)		Hispanic: ☐ Yes ☐ No		Date Last Worked
	See Attached Race/Ethnicity Worksheet		Specify: _____		
	Usual Occupation	Usual Kind of Business or Industry	Education – Years Completed	Social Security Number	
	Residence – Street Name and Number			County	
	City			State	Zip
	Mailing Address – If Different From Residence Address Street Name and Number or P.O. Box			County	
	City			State/Foreign County	Zip

Worksheet for Out-of-Hospital Births (Continued)

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Medical Data	Did Mother Receive WIC (Womens, Infants & Children) Food While Pregnant?			
	Average Number of Cigarettes/Packs Per Day First Three Months Prior to Pregnancy		Average Number of Cigarettes/Packs Per Day First Trimester	
	Average Number of Cigarettes/Packs Per Day Second Trimester		Average Number of Cigarettes/Packs Per Day Third Trimester	
	Prepregnancy Weight in Pounds	Delivery Weight in Pounds	Height Feet	Height Inches
	APGAR Score at 1 Minute (00-10, Unknown, or Not Taken)	APGAR Score at 5 Minutes (00-10, Unknown, or Not Taken)	APGAR Score at 10 Minutes (00-10, Unknown, or Not Taken)	Date Last Normal Menses Began
	Date First Prenatal Care Visit	Month Prenatal Care Began	Date Last Prenatal Care Visit	Number of Prenatal Visits
	Obstetric Estimate of Gestation at Delivery (Completed Weeks)		Hearing Screening: (Pass (Both Ears); Refer (One Ear); Refer (Both Ears); Results Pending; Waived; Not Medically Indicated; Test Not Available)	
PREGNANCY HISTORY (Complete Each Section)				
Live Births (Do not count this child)		Other Terminations (Exclude induced abortions)		
Now Living	Now Dead	Before 20 Weeks	After 20 Weeks	
Date of Last Live Birth		Date of Last Other Termination		
Enter Appropriate Codes From Worksheets	Principal Source of Payment for Prenatal Care	Birthweight in Grams (See attached birth weight conversion table)	Method of Delivery (See attached VS 10A worksheet)	
	Principal Source of Payment for Delivery	* Complications and Procedures of Pregnancy and Concurrent Illnesses (See attached VS 10A worksheet) Enter 00 for NONE		
	* Complications and Procedures of Labor and Delivery (See attached VS 10A worksheet) Enter 00 for NONE		* Abnormal Conditions and Clinical Procedures Related to the Newborn (See attached VS 10A worksheet) Enter 00 for NONE	
	* The attending physician or midwife shall complete these three fields for physician- or midwife-attended out-of-hospital births. These three fields are optional for non-physician- or non-midwife-attended out-of-hospital births.			