CERTIFICATE OF LIVE BIRTH WORKSHEET

PLEASE COMPLETE THIS INFORMATION TO PREPARE YOUR CHILD'S BIRTH CERTIFICATE:

FOR HOSPITAL USE ONLY:
ROOM # ______________
DELIVERY DR.: ______________

NAME OF CHILD:

FIRST: ______________ MIDDLE: ______________

LAST: ______________

SEX: MALE____ FEMALE____ WAS THIS BIRTH: SINGLE______ TWIN______ TRIPLET______ OTHER ______

IF MULTIPLE, THIS CHILD: 1ST ____ 2ND ____ 3RD ____ (CHECK APPRORIATE ENTRY)

CHILD'S DATE OF BIRTH: ______________ TIME OF BIRTH: ______________

ARE THE PARENTS MARRIED: YES _______ NO _______ SEPARATED ______ DIVORCED_______ SINGLE _______
AND/OR IN A STATE REGISTERED PARTNERSHIP (SRDP)? YES: ______ NO: ______

IF THE PARENTS ARE NOT MARRIED, THEN THE BIOLOGICAL PARENTS MUST SIGN PATERNITY PAPERS TO ADD THE FATHER'S NAME TO THE CHILD'S BIRTH CERTIFICATE. REFERENCE HEALTH AND SAFETY CODE SECTION 102425(A)(4)

BIRTH NAME OF PARENT GIVING BIRTH, UNLESS COURT ORDER IS PRESENTED (MOTHER OF NEWBORN):

FIRST: ______________ MIDDLE: ______________

LAST (MAIDEN): ______________ SSN: ______________

PHONE NUMBER: HOME ______________ CELL ______________

RELATIONSHIP TO CHILD: MOTHER_____ FATHER_____ PARENT _____ NOT SPECIFIED_____

BIRTHPLACE: ______________ (STATE OR FOREIGN COUNTRY) DATE OF BIRTH: ______________

BIRTH NAME OF PARENT NOT GIVING BIRTH (FATHER OF NEWBORN):

FIRST: ______________ MIDDLE: ______________

LAST: ______________ SSN: ______________

RELATIONSHIP TO CHILD: MOTHER_____ FATHER_______ PARENT _______ NOT SPECIFIED_______

BIRTHPLACE: ______________ (STATE OR FOREIGN COUNTRY) DATE OF BIRTH: ______________

FATHER'S INFORMATION:

RACE: (ENTER UP TO THREE RACES) ______________

IF HISPANIC, SPECIFY ORIGIN: ______________

USUAL OCCUPATION: ______________

KIND OF BUSINESS/INDUSTRY: ______________

EDUCATION:

CIRCLE HIGHEST DEGREE/LEVEL OF EDUCATION; ENTER HIGHEST YEAR COMPLETED _______(0-12TH GRADE);
RECEIVED HIGH SCHOOL DIPLOMA, YES_______ NO________, OR GED _________

SOME COLLEGE (NO DEGREE); ASSOCIATE DEGREES; BACHELORS DEGREE; MASTERS DEGREE; PROFESSIONAL, DOCTORATE

CONTINUE ON BACK PAGE

MOTHER'S INFORMATION:

RACE: (ENTER UP TO THREE RACES) ____________________

IF HISPANIC, SPECIFY ORIGIN: ____________________

USUAL OCCUPATION: ____________________

KIND OF BUSINESS/INDUSTRY: ____________________

EDUCATION:

CIRCLE HIGHEST DEGREE/LEVEL OF EDUCATION; ENTER HIGHEST YEAR COMPLETED _______(0-12TH GRADE);
RECEIVED HIGH SCHOOL DIPLOMA, YES_______ NO_______, OR GED _______

SOME COLLEGE (NO DEGREE); ASSOCIATE DEGREES; BACHELORS DEGREE; MASTERS DEGREE; PROFESSIONAL, DOCTORATE

BIRTH PARENT'S RESIDENCE ADDRESS (REQUIRED): ____________________

____
(ADDRESS, CITY, STATE, ZIP CODE, COUNTY P.O. BOXES ARE ACCEPTABLE)

MAILING ADDRESS (IF DIFFERENT): ____________________

____
(ADDRESS, CITY, STATE, ZIP CODE, COUNTY P.O. BOXES ARE ACCEPTABLE)

DID BIRTH PARENT RECEIVE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM FOOD DURING PREGNANCY?

YES: _____ NO: _____ UNKNOWN:_____

DID THE BIRTH PARENT SMOKE BEFORE OR DURING THE PREGNANCY? ENTER NUMBER OF CIGARETTES SMOKED PER DAY AS FOLLOWS:

DURING THE THREE MONTHS PRIOR TO BECOMING PREGNANT: ____________________
DURING THE FIRST THREE MONTHS OF PREGNANCY: ____________________
DURING THE SECOND THREE MONTHS OF PREGNANCY: ____________________
DURING THE LAST THREE MONTHS OF PREGNANCY: ____________________

BIRTH MOTHER'S PRE-PREGNANCY WEIGHT: _______ WEIGHT AT DELIVERY: _______ HEIGHT: _______

DATE OF LAST NORMAL MENSTRUAL PERIOD: ____________

DATE OF FIRST PRENATAL CARE VISIT: ____________ **DATE OF LAST PRENATAL CARE VISIT:** ____________
(DO NOT ENTER DELIVERY DATE)

NUMBER OF PRENATAL VISITS: _______ (IF UNSURE, ESTIMATE. DO NOT INCULDE NON-PREGNANCY RELATED VISITS TO EMERGENCY ROOM, VISIT TO CONFIRM PREGNANCY; NUTRITIONIST; DIETITIAN; HEALTH EDUCATOR, ETC., NORMAL PRENATAL VISIT APPROXIMATELY 16)

BIRTHWEIGHT OF BABY: ____________

HEARING RESULTS: PASS BOTH:_____ REFER ONE: _____ REFER BOTH: _____ RESULTS PENDING: _____

NUMBER OF PREVIOUS LIVE BIRTHS (DO NOT COUNT THIS CHILD): _____

NUMBER OF LIVE BIRTHS NOW DECEASED: _______

DATE OF LAST LIVE BIRTH: _______ (DO NOT COUNT THIS CHILD)

NUMBER OF MISCARRIAGES BEFORE 20 WEEKS: _____ **AFTER 20 WEEKS:**_____ (DO NOT COUNT ABORTIONS)

DATE OF LAST MISCARRIAGE ____________

SOCIAL SECURITY REQUEST ON 2nd PAGE

REQUESTING THE CHILD'S SOCIAL SECURITY NUMBER THROUGH THE BIRTH CERTIFICATE PROCESS

NOTICE TO PARENTS: Completion of this form in the hospital will enable you to receive a valuable service from the federal government. Federal law requires that a Social Security Number be provided for all dependents listed on federal tax forms. A Social Security Number is also necessary when applying for welfare or other public assistance benefits for your child. By completing this form and requesting a Social Security Number for your new baby, the California Department of Public Health will transmit your request to the Social Security Administration, and a card will be mailed to you usually within six weeks, eliminating the need for you to personally visit a Social Security office with evidence of your child's identity, birth date, and citizenship.

For certified copies of your child's birth certificate, contact the health department or the recorder's office of the county where the birth occurred. You may also obtain an application for a certified copy through the California Department of Public Health by calling (916) 445-2684 or by visiting the web site at www.cdph.ca.gov.

NEWBORN AUTOMATICE NUMBER ASSIGNMENT
(NANA)

Baby's Name as Reported on Birth Certificate:

____

(A SOCIAL SECURITY NUMBER CANNOT BE ISSUED FOR A CHILD THAT HAS NOT BEEN NAME.)

1. Do you want a Social Security Number (SSN) for your new baby?

   ________ Yes ________ No

Please contact the Social Security Administration at 1-800-772-1213 or www.ssa.gov for questions or concerns regarding the issuance of your child's Social Security number or Social Security care.

I acknowledge that I am responsible for reviewing my child's birth certificate for accuracy and that the birth certificate worksheet is only retained for a limited time period. Beyond that, it will not be the responsibility of the hospital to amend the birth certificate for anything other than an incorrect date of birth, time of birth, sex of infant, or hospital error. All other amendments to the birth certificate are the responsibility of the parent.

_______________________________ _______________________________

Parent's Signature Date

____

Parent's Printed Name

This form should be completed and signed by the child's parent(s).