TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD

CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

BIRTH NUMBER

CHILD

1. CHILD'S NAME *(First, Middle, Last)*
2. DATE OF BIRTH *(Month, Day, Year)*
3. TIME OF BIRTH — M
4. SEX
5. CITY, TOWN, OR LOCATION OF BIRTH
6. COUNTY OF BIRTH
7. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other *(Specify)* _____
8. FACILITY NAME *(If not institution, give street and number)*

CERTIFIER/ ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated. *Signature* ▶
10. DATE SIGNED *(Month, Day, Year)*
11. ATTENDANT'S NAME AND TITLE *(If other than certifier) (Type/Print)* Name _____ ☐ M.D ☐ D O ☐ C N M ☐ Other Midwife ☐ Other *(Specify)* _____
12. CERTIFIER'S NAME AND TITLE *(Type/Print)* Name _____ ☐ M.D. ☐ D.O. ☐ Hospital Admin. ☐ C.N.M. ☐ Other Midwife ☐ Other *(Specify)* _____
13. ATTENDANT'S MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DEATH UNDER ONE YEAR OF AGE Enter State File Number of death certificate for this child

14. REGISTRAR'S SIGNATURE ▶
15. DATE FILED BY REGISTRAR *(Month, Day, Year)*

MOTHER

16a. MOTHER'S NAME *(First, Middle, Last)*
16b. MAIDEN SURNAME
17. DATE OF BIRTH *(Month, Day, Year)*
18. BIRTHPLACE *(State or Foreign Country)*
19a. RESIDENCE—STATE
19b. COUNTY
19c. CITY, TOWN, OR LOCATION
19d. STREET AND NUMBER
19e. INSIDE CITY LIMITS? *(Yes or no)*
20. MOTHER'S MAILING ADDRESS *(If same as residence, enter Zip Code only)*

FATHER

21. FATHER'S NAME *(First, Middle, Last)*
22. DATE OF BIRTH *(Month, Day, Year)*
23. BIRTHPLACE *(State or Foreign Country)*

INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. *Signature of Parent or Other Informant* ▶

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

25. OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)	26. RACE—American Indian, Black, White, etc. *(Specify below)*	27. EDUCATION *(Specify only highest grade completed)* — Elementary/Secondary (0-12) | College (1-4 or 5+)
MOTHER 25a. ☐ No ☐ Yes Specify:	26a.	27a.
FATHER 25b. No ☐ Yes Specify:	26b.	27b.

28. PREGNANCY HISTORY *(Complete each section)*	29. MOTHER MARRIED? (At birth, conception, or any time between) *(Yes or no)*	30. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*
LIVE BIRTHS *(Do not include this child)*: 28a. Now Living Number _____ ☐ None; 28b. Now Dead Number _____ ☐ None	31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*	32. PRENATAL VISITS—Total Number *(If none, so state)*
OTHER TERMINATIONS *(Spontaneous and induced at any time after conception)*: 28d. Number _____ ☐ None	33. BIRTH WEIGHT *(Specify unit)*	34. CLINICAL ESTIMATE OF GESTATION *(Weeks)*
28c. DATE OF LAST LIVE BIRTH *(Month, Year)*	35a. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*	35b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. *(Specify)*
28e. DATE OF LAST OTHER TERMINATION *(Month, Year)*		

MULTIPLE BIRTHS Enter State File Number for Mate(s) LIVE BIRTH(S)

FETAL DEATH(S)

36. APGAR SCORE	37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If Yes, enter name of facility transferred **from:**
36a. 1 Minute | 36b. 5 Minutes	37b. INFANT TRANSFERRED? ☐ No ☐ Yes If Yes, enter name of facility transferred **to:**

38a. MEDICAL RISK FACTORS FOR THIS PREGNANCY
(Check all that apply)

- Anemia (Hct. < 30/Hgb. < 10) ... 01 ☐
- Cardiac disease ... 02 ☐
- Acute or chronic lung disease ... 03 ☐
- Diabetes ... 04 ☐
- Genital herpes ... 05 ☐
- Hydramnios/Oligohydramnios ... 06 ☐
- Hemoglobinopathy ... 07 ☐
- Hypertension, chronic ... 08 ☐
- Hypertension, pregnancy-associated ... 09 ☐
- Eclampsia ... 10 ☐
- Incompetent cervix ... 11 ☐
- Previous infant 4000 + grams ... 12 ☐
- Previous preterm or small-for-gestational-age infant ... 13 ☐
- Renal disease ... 14 ☐
- Rh sensitization ... 15 ☐
- Uterine bleeding ... 16 ☐
- None ... 00 ☐
- Other _____ 17 ☐
  (Specify)

38b. OTHER RISK FACTORS FOR THIS PREGNANCY
(Complete all items)

Tobacco use during pregnancy ... Yes ☐ No ☐
Average number cigarettes per day _____
Alcohol use during pregnancy ... Yes ☐ No ☐
Average number drinks per week _____
Weight gained during pregnancy _____ lbs.

39. OBSTETRIC PROCEDURES
(Check all that apply)

- Amniocentesis ... 01 ☐
- Electronic fetal monitoring ... 02 ☐
- Induction of labor ... 03 ☐
- Stimulation of labor ... 04 ☐
- Tocolysis ... 05 ☐
- Ultrasound ... 06 ☐
- None ... 00 ☐
- Other _____ 07 ☐
  (Specify)

40. COMPLICATIONS OF LABOR AND/OR DELIVERY
(Check all that apply)

- Febrile (> 100 °F. or 38 °C.) ... 01 ☐
- Meconium, moderate/heavy ... 02 ☐
- Premature rupture of membrane (> 12 hours) 03 ☐
- Abruptio placenta ... 04 ☐
- Placenta previa ... 05 ☐
- Other excessive bleeding ... 06 ☐
- Seizures during labor ... 07 ☐
- Precipitous labor (< 3 hours) ... 08 ☐
- Prolonged labor (> 20 hours) ... 09 ☐
- Dysfunctional labor ... 10 ☐
- Breech/Malpresentation ... 11 ☐
- Cephalopelvic disproportion ... 12 ☐
- Cord prolapse ... 13 ☐
- Anesthetic complications ... 14 ☐
- Fetal distress ... 15 ☐
- None ... 00 ☐
- Other _____ 16 ☐
  (Specify)

41. METHOD OF DELIVERY *(Check all that apply)*

- Vaginal ... 01 ☐
- Vaginal birth after previous C-section ... 02 ☐
- Primary C-section ... 03 ☐
- Repeat C-section ... 04 ☐
- Forceps ... 05 ☐
- Vacuum ... 06 ☐

42. ABNORMAL CONDITIONS OF THE NEWBORN
(Check all that apply)

- Anemia (Hct. < 39/Hgb. < 13) ... 01 ☐
- Birth injury ... 02 ☐
- Fetal alcohol syndrome ... 03 ☐
- Hyaline membrane disease/RDS ... 04 ☐
- Meconium aspiration syndrome ... 05 ☐
- Assisted ventilation < 30 min ... 06 ☐
- Assisted ventilation ≥ 30 min ... 07 ☐
- Seizures ... 08 ☐
- None ... 00 ☐
- Other _____ 09 ☐
  (Specify)

43. CONGENITAL ANOMALIES OF CHILD
(Check all that apply)

- Anencephalus ... 01 ☐
- Spina bifida/Meningocele ... 02 ☐
- Hydrocephalus ... 03 ☐
- Microcephalus ... 04 ☐
- Other central nervous system anomalies *(Specify)* _____ 05 ☐
- Heart malformations ... 06 ☐
- Other circulatory/respiratory anomalies *(Specify)* _____ 07 ☐
- Rectal atresia/stenosis ... 08 ☐
- Tracheo-esophageal fistula/ Esophageal atresia ... 09 ☐
- *Omphalocele*/ Gastroschisis ... 10 ☐
- Other gastrointestinal anomalies *(Specify)* _____ 11 ☐
- Malformed genitalia ... 12 ☐
- Renal agenesis ... 13 ☐
- Other urogenital anomalies *(Specify)* _____ 14 ☐
- Cleft lip/palate ... 15 ☐
- Polydactyly/Syndactyly/Adactyly 16 ☐
- Club foot ... 17 ☐
- Diaphragmatic hernia ... 18 ☐
- Other musculoskeletal/integumental anomalies *(Specify)* _____ 19 ☐
- Down's syndrome ... 20 ☐
- Other chromosomal anomalies *(Specify)* _____ 21 ☐
- None ... 00 ☐
- Other _____ 22 ☐
  (Specify)