DATE FILED BY STATE REGISTRAR: ____________

State of Idaho

# CERTIFICATE OF LIVE BIRTH

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE DEPARTMENT OF HEALTH AND WELFARE RAISED SEAL SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS BIRTH UNDER IDAHO CODE 39-241(k) AND 39-274

STATE FILE NO. ____________

SAMPLE

**CHILD**

| 1. CHILD'S NAME (First, Middle, Last, Suffix) | 2. TIME OF BIRTH (24 hr) | 3. SEX | 4. DATE OF BIRTH (Mo/Day/Yr) |
|---|---|---|---|
| 5. FACILITY NAME (If not facility, give street and number) | 6. CITY, TOWN, OR LOCATION OF BIRTH | 7. COUNTY OF BIRTH | |

**MOTHER**

| 8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | | | 8b. DATE OF BIRTH (Mo/Day/Yr) |
|---|---|---|---|
| 8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) | | | 8d. BIRTHPLACE (State, Territory, or Foreign Country) |
| 9a. RESIDENCE OF MOTHER - STATE | 9b. COUNTY | 9c. CITY, TOWN, OR LOCATION | |
| 9d. STREET AND NUMBER | 9e. APT. NO. | 9f. ZIP CODE | 9g. INSIDE CITY LIMITS? ☐ Yes ☐ No |

TYPE/PRINT IN PERMANENT BLACK INK

FOR INSTRUCTIONS SEE HANDBOOK

**FATHER**

| 10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 10b. DATE OF BIRTH (Mo/Day/Yr) | 10c. BIRTHPLACE (State, Territory, or Foreign Country) |
|---|---|---|

**INFORMANT**

11. INFORMANT'S SIGNATURE: I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.

(Name of Parent or Guardian)▸

**CERTIFIER**

12a. CERTIFIER'S SIGNATURE: I certify that stated information concerning this child is true to the best of my knowledge and belief.

Certifier's Signature ▸ ____________

Name (Type or print) ____________

12b. CERTIFIER'S MAILING ADDRESS (Street and Number, City, State, Zip Code)

12c. CERTIFIER'S LICENSE NUMBER

12d. DATE SIGNED ___/___/___ MM DD YYYY

12e. CERTIFIER'S TITLE ☐ MD ☐ DO ☐ Hospital Administrator ☐ CNM/CM ☐ Other Midwife ☐ Other (Specify) ____________

**INFORMATION FOR MEDICAL AND HEALTH USE ONLY - COMPLETE EACH ITEM**

**ADMINISTRATIVE USE ONLY**

13. MOTHER'S MAILING ADDRESS: ☐ Same as residence, OR: State ____________ City, Town, or Location ____________

Street and Number ____________ Apartment Number ____________ Zip Code ____________

14. MOTHER MARRIED? (at birth, conception, or any time between) ☐ Yes ☐ No

IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? ☐ Yes ☐ No

15. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No

16. MOTHER'S SOCIAL SECURITY NUMBER

17. FATHER'S SOCIAL SECURITY NUMBER

18. CONSENT OBTAINED FOR IMMUNIZATION REGISTRY ENROLLMENT? ☐ Yes ☐ No

**MEDICAL AND HEALTH SECTION** Complete Each Item

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

19. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

1☐ 8th grade or less (includes none)
2☐ 9th-12th grade, but no diploma
3☐ High school graduate or GED completed
4☐ Some college credit, but no degree
5☐ Associate degree (eg. AA, AS)
6☐ Bachelor's degree (eg, AB, BA, BS)
7☐ Master's degree (eg. MA, MBA, MEd, MEng, MS, MSW)
8☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

20. MOTHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

0☐ No, not Spanish/Hispanic/Latina
1☐ Yes, Mexican, Mexican American, Chicana
2☐ Yes, Puerto Rican
3☐ Yes, Cuban
4☐ Yes, other Spanish/Hispanic/Latina

(Specify) ____________

21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

01☐ White
02☐ Black or African American
03☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ____________
04☐ Asian Indian
05☐ Chinese
06☐ Filipino
07☐ Japanese
08☐ Korean
09☐ Vietnamese
10☐ Other Asian (Specify) ____________
11☐ Native Hawaiian
12☐ Guamanian or Chamorro
13☐ Samoan
14☐ Other Pacific Islander (Specify) ____________
15☐ Other (Specify) ____________

MULTIPLE BIRTHS Enter State File Number(s) of mate(s)

LIVE BIRTH(S) ____________

STILLBIRTH(S) ____________

22. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

1☐ 8th grade or less (includes none)
2☐ 9th-12th grade, but no diploma
3☐ High school graduate or GED completed
4☐ Some college credit, but no degree
5☐ Associate degree (eg. AA, AS)
6☐ Bachelor's degree (eg, AB, BA, BS)
7☐ Master's degree (eg. MA, MBA, MEd, MEng, MS, MSW)
8☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

23. FATHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latina)

0☐ No, not Spanish/Hispanic/Latino
1☐ Yes, Mexican, Mexican American, Chicano
2☐ Yes, Puerto Rican
3☐ Yes, Cuban
4☐ Yes, other Spanish/Hispanic/Latino

(Specify) ____________

24. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

01☐ White
02☐ Black or African American
03☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ____________
04☐ Asian Indian
05☐ Chinese
06☐ Filipino
07☐ Japanese
08☐ Korean
09☐ Vietnamese
10☐ Other Asian (Specify) ____________
11☐ Native Hawaiian
12☐ Guamanian or Chamorro
13☐ Samoan
14☐ Other Pacific Islander (Specify) ____________
15☐ Other (Specify) ____________

25. PLACE WHERE BIRTH OCCURRED (Check one)

☐ Hospital
☐ Freestanding birthing center
☐ Home birth
Planned to deliver at home? ☐ Yes ☐ No
☐ Clinic/Doctor's Office
☐ Other Specify ____________

26. ATTENDANT'S NAME AND TITLE

NAME ____________

TITLE ☐ MD ☐ DO ☐ CNM/CM ☐ Other Midwife

☐ Other (Specify) ____________

27. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM: ____________

COMPLETE REVERSE SIDE

**MEDICAL AND HEALTH SECTION** Complete Each Item

**28a. DATE OF FIRST PRENATAL CARE VISIT**
___/___/_____ MM DD YYYY ☐ No Prenatal Care

**28b. DATE OF LAST PRENATAL CARE VISIT**
___/___/_____ MM DD YYYY ☐ No Prenatal Care

**29. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY**
_______________ (IF NONE, ENTER "O")

**30. MOTHER'S HEIGHT**
_____________ (feet/inches)

**31. MOTHER'S PREPREGNANCY WEIGHT**
_____________ (pounds)

**32. MOTHER'S WEIGHT AT DELIVERY**
_____________ (pounds)

**33. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?**
☐ Yes ☐ No

**PREGNANCY HISTORY** (Complete each section)

**PREVIOUS LIVE BIRTHS**
(Do not include this child)
Complete items 34a-34c

**34a. Now Living**
Number_____
☐ None

**34b. Now Dead**
Number_____
☐ None

**34c. DATE OF LAST LIVE BIRTH**
___/_____ MM YYYY

**OTHER PREGNANCY OUTCOMES**
(spontaneous or induced losses or ectopic pregnancies)
Complete items 35a-35b

**35a. Other Outcomes**
Number_____
☐ None

**35b. DATE OF LAST OTHER PREGNANCY OUTCOME**
___/_____ MM YYYY

**36. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY**
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked (IF NONE, ENTER "0")
**Average number of cigarettes or packs of cigarettes smoked per day:**

| | # OF CIGARETTES | | # OF PACKS |
|---|---|---|---|
| Three months before pregnancy | ______ | OR | ______ |
| First three months of pregnancy | ______ | OR | ______ |
| Second three months of pregnancy | ______ | OR | ______ |
| Last three months of pregnancy | ______ | OR | ______ |

**37. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY**
1☐ Private insurance
2☐ Medicaid
3☐ Self-pay
4☐ Indian Health Service
5☐ CHAMPUS/TRICARE
6☐ Other government (federal, state, local)
8☐ Other
0☐ None

**38. DATE LAST NORMAL MENSES BEGAN**
___/___/_____ MM DD YYYY

**39. WAS SYPHILIS SEROLOGY PERFORMED FOR THIS PREGNANCY?**
☐ Yes ☐ No ☐ Refused

**MEDICAL AND HEALTH SECTION** Complete Each Item

**40. RISK FACTORS IN THIS PREGNANCY** (Check all that apply)
Diabetes:
01☐ Prepregnancy (diagnosis prior to this pregnancy)
02☐ Gestational (diagnosis in this pregnancy)
Hypertension:
03☐ Prepregnancy (chronic)
04☐ Gestational (PIH, preeclampsia, eclampsia)
05☐ Previous preterm birth
06☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
07☐ Vaginal bleeding during this pregnancy prior to the onset of labor
08☐ Pregnancy resulted from infertility treatment
09☐ Mother had a previous cesarean delivery
If yes, how many?_____________
00☐ None of the above

**41. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY** (Check all that apply)
01☐ Gonorrhea
02☐ Syphilis
03☐ HIV Infection
04☐ Herpes Simplex Virus (HSV)
05☐ Chlamydia
06☐ Listeria
07☐ Group B Streptococcus
08☐ Cytomegalovirus
09☐ Parvovirus
10☐ Toxoplasmosis
11☐ Hepatitis B
12☐ Hepatitis C
13☐ Other
(Specify)_____________
00☐ None

**42. OBSTETRIC PROCEDURES**
(Check all that apply)
1☐ Cervical Cerclage
2☐ Tocolysis
External cephalic version:
3☐ Successful
4☐ Failed
0☐ None of the above

**43. ONSET OF LABOR**
(Check all that apply)
1☐ Premature rupture of the membranes (prolonged, ≥ 12 hrs.)
2☐ Precipitous labor (< 3 hrs.)
3☐ Prolonged labor (≥ 20 hrs.)
0☐ None of the above

**44. CHARACTERISTICS OF LABOR AND DELIVERY**
(Check all that apply)
01☐ Induction of labor
02☐ Augmentation of labor
03☐ Non-vertex presentation
04☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
05☐ Antibiotics received by the mother during labor
06☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
07☐ Moderate/heavy meconium staining of the amniotic fluid
08☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
09☐ Epidural or spinal anesthesia during labor
00☐ None of the above

**45. METHOD OF DELIVERY**
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No
C. Fetal presentation at birth (Check one)
☐ Cephalic
☐ Breech
☐ Other
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

**46. MATERNAL MORBIDITY** (complications associated with labor and delivery)
(Check all that apply)
1☐ Maternal transfusion
2☐ Third or fourth degree perineal laceration
3☐ Ruptured uterus
4☐ Unplanned hysterectomy
5☐ Admission to intensive care unit
6☐ Unplanned operating room procedure following delivery
0☐ None of the above

**47. MOTHER'S MEDICAL RECORD NUMBER**

**MEDICAL AND HEALTH SECTION** Complete Each Item

**48. NEWBORN'S MEDICAL RECORD NUMBER**

**49. BIRTH WEIGHT** (Check unit, grams preferred)
☐ grams
OR _____________
☐ lb/oz

**50. OBSTETRIC ESTIMATE OF GESTATION**
_____________ (completed weeks)

**51. APGAR SCORE**
Score at 5 minutes _____________
**If 5 minute score is less then 6,**
Score at 10 minutes _____________

**52. PLURALITY** (single, twin, triplet, etc.)
(Specify) _____________

**53. IF NOT SINGLE BIRTH** (born first, second, third, etc.)
(Specify) _____________

**54. IS INFANT BEING BREASTFED?**
☐ Yes ☐ No

**55. ABNORMAL CONDITIONS OF THE NEWBORN**
(Check all that apply)
1☐ Assisted ventilation required immediately following delivery
2☐ Assisted ventilation required for more than six hours
3☐ NICU admission
4☐ Newborn given surfactant replacement therapy
5☐ Antibiotics received by the newborn for suspected neonatal sepsis
6☐ Seizure or serious neurologic dysfunction
7☐ Significant birth injury (skeletal fracture, peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
8☐ Failed newborn hearing test
0☐ None of the above

**56. CONGENITAL ANOMALIES OF THE NEWBORN**
(Check all that apply)
01☐ Anencephaly
02☐ Meningomyelocele/Spina bifida
03☐ Cyanotic congenital heart disease
04☐ Congenital diaphragmatic hernia
05☐ Omphalocele
06☐ Gastroschisis
07☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
08☐ Cleft lip with or without cleft palate
09☐ Cleft palate alone
Down Syndrome:
10☐ Karyotype confirmed
11☐ Karyotype pending
Suspected other chromosomal disorder:
12☐ Karyotype confirmed
13☐ Karyotype pending
14☐ Hypospadias
00☐ None of the above

**57. WAS AN APPROVED PROPHYLACTIC AGENT USED IN INFANT'S EYES?**
☐ Yes ☐ No If "No", reason: _____________

**58. WAS SAMPLE COLLECTED FOR NEWBORN METABOLIC SCREENING TESTS?**
☐ Yes ☐ No If "No", reason: _____________

**59. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY?** ☐ Yes ☐ No
**IF "YES", NAME OF FACILITY INFANT TRANSFERRED TO:**
_____________

**60. IS INFANT LIVING AT TIME OF REPORT?**
☐ Yes ☐ No ☐ Infant transferred, status unknown