Birth Worksheet – Midwife Only

1A First Name of Child		2B Middle name of child	3C Last name of child	
2.Sex	3A This fetus, single,twin	3B. This fetus, 1st, 2nd	4A. DOB	4B Hour of birth
5A Place of birth		5B Street address-Street, umber or location		
5C City		5D County		
6A Father's first name	6B Middle	6C Last	7. Birth Place	8. DOB
9A Mother's first name	9B Middle	9C Last (maiden)	10. Birthplace	11. DOB
13D Attendant's name, title and license number				

Not a Legal Document

19. Father's race	18. Hispanic?	20C. Education		
20. Date last worked (father)	20A. Usual Occupation	20B. Kind of Business		
22. Mother's race	21. Hispanic?	23C. Education		
23. Date last worked (mother)	23A. Usual occupation	23C Kind of Business		
24A. Mother's Residence-street and number		24B. County		
24C. City	24D. State	23C. Zip Code		
25A. Date of last menses	25AA. Date of 1st prenatal visits	25D. Month prenatal care began		
25BA. Date of last prenatal visit	25C. Number of prenatal visits	25D. Source of prenatal care		
26A Birth weight (grams)	Previous live births (do not include this one)	Other terminations (exclude induced abortions)		
26A OB Est. wks of gest @ del.	A. # now Living	B. # Now Dead	D. # <20 wks.	E. #>20wks
26B Hearing Screening	C. Date of last live birth mo/day/yr	F. Date of last other term. Mo/yr		
28. Method of Delivery	A	B.	C.	D.	E.
28B. Source of delivery pay	29. Complications, procedures, illness of pregnancy			
30. Complications & procedures of labor & delivery	31. Abnormal conditions related to newborn			
FOB SS#	MOB SS#	Phone #		

Were parents married at time of birth? Yes____ No_____

Was NBS test done? Yes____ No____ Date: _____

Mother's current last name: _____

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Name of Child: _____ Date of Birth_____

This information is required by state for birth registration. The following

Information will not be printed on the birth certificates

For statistical use only

Mother's mailing address:

Street Number and Name or P.O. Box: _____
County: _____
City: _____
State: _____
Zip: _____

Did mother receive WIC (Women, Infants & Children) food while pregnant with this child?
Yes_____ No_____ Unknown_____

How many cigarettes or packs of cigarettes did the mother smoke during each of the following time periods?

	# of cigarettes		# of packs
Three months before pregnancy:	_____	or	_____
First Three months of pregnancy:	_____	or	_____
Second three months of pregnancy:	_____	or	_____
Third trimester of pregnancy:	_____	or	_____

Mother's Pre-pregnancy weight-pounds: _____

Mother's delivery weight-pounds: _____

Mother's height: _____

APGAR score:

At 1 minute: _____ At 5 minutes: _____ At 10 minutes: _____

(00-10: unknown or not taken)

Butte County
PUBLIC HEALTH

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Affidavit of Birth Information for Out-of-Hospital Births

This Affidavit is to be completed at the Local Health Office

I swear or affirm that the information stated is true and correct to the best of my knowledge and belief. I certify that the child named herein was born alive to the stated mother at the place, date, and time shown on this worksheet.

This worksheet was completed with the understanding that the facts so stated herein afford a full, complete, and truthful representation of facts and what my testimony shall be should I be asked or directed to testify to the facts herein in a court of law. I realize that any false statement of facts or information made herein could subject me to the risk of criminal liability, including, but not limited to, prosecution for perjury.

Parent Verification	Printed Name	Written Signature ►	
	Relationship to Child □ Mother/Parent □ Father/Parent	Date Signed	Phone Number ( )
Witness Verification	Printed Name	Written Signature ►	
	Address – Street Name and Number		County
	City	State	Zip
	Relationship to Child	Date Signed	Phone Number ( )
Attendant Verification **(Physician, Certified Nurse-Midwife, or Licensed Midwife)**	Printed Name	Written Signature ►	
	Address – Street Name and Number		County
	City	State	Zip
	State License Number	Date Signed	Phone Number ( )
Local Registration District Staff Verification	Printed Name	Written Signature ►	
	Date Signed	□ Registered	□ Denied Inventory Control Number _____

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Privacy Notification

The information entered on the worksheet will be transferred to the Certificate of Live Birth (VS 10D) and will be collected by the California Department of Public Health Vital Records, 1501 Capitol Avenue, M.S. 5103, P.O. Box 997410, Sacramento, CA 95899-7410, telephone number (916) 445-2684. This information is required by Division 102 of the Health and Safety Code. Every element on the worksheet is mandatory, except the items between the double bold lines on the first page of the worksheet. Failure to comply by every person, except a parent informant, is a misdemeanor. The Certificate of Live Birth is open to public access except where prohibited by statute. The principal purposes of this record are to: 1) Establish a legal record of each vital event, 2) Provide certified copies for personal use, 3) Furnish information for demographic and epidemiological studies, and 4) Supply data to the National Center for Health Statistics for federal reports. The father's and the mother's Social Security numbers are included pursuant to Section 102425 (b) (14) of the Health and Safety Code, and may be used for child support enforcement purposes.