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Registration of a Home Birth:

You will find the following items attached with information on filing your new babies birth certificate.

- **Instructions from the State Dept. of Health** concerning all things that needs to be provided to the Local Registrar (County Clerk) in order to register your child's birth.
- **Parent Worksheet for Child's Birth Certificate**—**MUST** be filled out **COMPLETELY** and **LEGIBLY** so that your child's Birth Certificate will be entered correctly.
- **ImmTrac** information/brochure and form to fill out if you choose to register for this.

The mother and father will have to personally appear, either together or separately, before the County Clerk with identification, as well as the infant being brought into the office to be seen by the County Clerk.

Once all the paperwork is completed, please bring it in to the County Clerk's office (803 Pine Street, Room 112, Bastrop).

If you have any questions, please don't hesitate to call me at one of the numbers listed above.

Thank you,

Krista Bartsch

Krista Bartsch

1.7.2 NON-INSTITUTIONAL BIRTH NOT ATTENDED BY A REGISTERED, CERTIFIED, OR DOCUMENTED HEALTH CARE PROVIDER.

If there is no physician, midwife, or person acting as midwife in attendance at a noninstitutional birth, documentation is required from the parent(s) before a birth certificate may be filed.

In an effort to control fraudulent filings of birth records and to place control over blank forms, the Texas Vital Statistics Section (VSS) and Texas Board of Health developed and approved rules for filing birth certificates for children born outside licensed institutions [TAC §181.26]. To insure uniform compliance throughout the state, VSS developed the following administrative comments and instructions.

To file a birth certificate with the appropriate local registrar the following proof must be presented to the local registrar by the person in attendance at the birth in the following order of preference:

1. The father or mother of the child; or
2. The owner or householder of the premises where the birth occurs.

The registrar may provide to the person filing the birth record a “Mothers Work Sheet” in order to gather the information to be placed on the birth record.

A birth certificate can be filed only upon personal presentation of the following evidence:

PROOF OF PREGNANCY, PRESENTED IN FOLLOWING ORDER OF PREFERENCE;

- An affidavit (notarized) presented from a licensed, registered, or certified health care provider who is qualified to determine pregnancy as part of the scope of his or her license or registration, or certification; or
- An affidavit (notarized) along with photocopy of ID (for example, a driver’s license or government ID, etc.) presented from one person, other than the parents, having knowledge of the pregnancy/birth

PROOF THAT THE INFANT WAS BORN ALIVE;

- A medical record or a letter from a licensed, registered, or certified health care provider or medical institution; or
- An affidavit (notarized) along with photocopy of ID (for example, a driver’s license or government ID, etc.) presented from one person, other than the parents, having knowledge of the pregnancy/birth.

PROOF THAT THE INFANT WAS BORN IN THE REGISTRATION DISTRICT;

- If the birth occurred outside the mother's primary place of residence, proof shall consist of an affidavit (notarized) along with a photocopy of ID from a person having knowledge of the mother's presence in the registration district on the date of the birth.
- If the birth occurred in the mother's primary place of residence, proof of residence in the following order of preference:
 - A utility bill, telephone, or other bill, which includes the mother's name and address;
 - A rent receipt which includes the mother's name, address, and signature of the mother's landlord;
 - A driver's license, or state issued identification card, which includes the mother's current address on the face of the license or card;
 - An envelope addressed to the mother at her place of residence, and post marked prior to the date of birth; or
 - An affidavit (notarized) attesting to the mother's place of residence along with a photocopy of ID from a person, other than the father, who was either living with the mother at the time of the alleged birth, or has other knowledge of the mother's residency.

PROOF THAT THE INFANT WAS BORN ON THE DATE STATED.

- A medical record or a letter from a licensed, registered, or certified health care provider or medical institution; or
- An affidavit (notarized) presented from one person along with photocopy of ID, other than the parents, having knowledge of the pregnancy/birth.

OTHER SUPPLEMENTAL INFORMATION PROVING HOME BIRTH

At the discretion of the local registrar, these procedures may be supplemented with any additional requirements needed to verify the circumstances of the birth. Additional requirements may include, but are not limited to, one or more of the following:

- An unannounced visit by a public health nurse, other health professional, registrar staff, or other person including city, county, state, or federal law enforcement officers, prior to registering the birth. This paragraph does not permit nor give authority to enter these premises unless permission is obtained from the occupant at the time of the visit;
- Multiple forms of identifying documents, with or without photographs, when the documents described in this section are unavailable;

- Personal appearance of both parents, either together or separately; or
- Personal appearance of the infant whose birth certificate the parents are attempting to file

PERSONS AND/OR RECORDS NOT MEETING REQUIREMENTS FOR FILING

If the local registrar did not feel the documentation requirements were met, the local registrar shall contact VSS Field services and provide their representative with a copy of the required documentation for review.

The documentation that has been submitted as proof should be returned to the person filing the record after the birth record is accepted.

Each local registrar must notify the Fraud Prevention Program of any suspicious documents or records submitted or filed with his/her office.

If the individual(s) attempting to file the birth records of a child not born in an institution cannot meet the four essential elements required for filing (proof of pregnancy, proof the infant was born alive, proof the infant was born in the registration district, and proof the infant was born on the date stated), the local registrar will forward the record and all documentation to the State Registrar for his/her determination.

- The local registrar will send a cover letter with the documentation explaining why he/she cannot accept the record for filing.
- The local registrar will give a letter to the parent(s) and/or person trying to file the record telling them why he or she cannot accept the record for filing and that the request and documentation have been sent to Austin for the State Registrar's determination.
- Upon receipt of the birth record from the local registrar within one year of the date of birth, the State Registrar will direct the Fraud Prevention Program to further verify or investigate as necessary to determine to accept or not accept the documentation sent. If the documentation is deemed unacceptable, the State Registrar will send a letter referring the parent(s) to a Texas district court for a judicial determination and order to file a Certificate of Birth. If the birth occurred more than a year before the parent(s) attempt to file a delayed birth certificate, and the documentation is deemed unacceptable, the State Registrar may refer the case to the county judge of the alleged county of birth for a judicial decision [TAC §182.26(1), HSC §192.027].

1.8 ACKNOWLEDGEMENT OF PATERNITY (AOP)

When the biological father and mother are not married (or the marriage ended within 300 days of the child's birth), this form is signed by both parents to establish a legal finding of paternity. The biological father becomes the legal father and has all rights and duties of a parent. His name may go on the birth certificate. A certified person will assist in the AOP

process. See the Acknowledgement of Paternity (AOP) handbook from the Office of Attorney General (OAG) for details on the process.

1.9 PATERNITY REGISTRY

The Texas Vital Statistic Section has established a Paternity Registry for men to assert voluntarily their parental rights. The purpose of the Paternity Registry is to “protect the parental rights of fathers who affirmatively assume responsibility for children they have fathered, and expedite adoptions of children whose biological fathers are unwilling to assume responsibility for their children by registering with the registry or otherwise acknowledging their children” [TFC §160.251(b) (1-2)].

A man is not required to register with the Paternity Registry. It is unnecessary for him to register if he is listed as the biological father on the child’s birth certificate, if he has completed an AOP with the child’s mother, or if he has been adjudicated to be the biological father of the child by a court of competent jurisdiction. The Paternity Registry does provide an opportunity for a father to assert his parental rights when he cannot complete the AOP or be listed as the father on a child’s birth certificate.

1.10 NOTICE OF INTENT TO CLAIM PATERNITY

The Notice of Intent to Claim Paternity form is used to add the father’s name to the Paternity Registry maintained by the Vital Statistic Section (VSS) [TFC 160.256]. A man who wishes to claim paternity for a child he may have fathered can complete a “Notice of Intent to Claim Paternity.” This form is used in situations where the father and mother do not have a continuing relationship, and the man is not listed as the father on the birth certificate or AOP or when the biological father is unable to sign the AOP because he and the mother cannot obtain a denial of paternity from the man to whom she was married at or within 300 days before the birth.

The Notice of Intent form must be filed before or within 30 days of the date of birth of a child [TFC 160.256]. The man should also be encouraged to obtain legal advice and petition the court for the establishment of legal paternity.

The Notice of Intent form will not legally establish paternity, nor can it be used to add a man’s name to the child’s birth certificate. It is simply an assertion of belief that he is the father of a child and wishes to preserve his rights as a parent.

The following is a list of examples (not all-inclusive) in which the man may use the Notice of Intent to Claim Paternity form to register his assertion of paternity to protect his rights:

- A man and woman have a consenting sexual relationship for a brief period of time, and they have no further contact. The man understands the woman may have become pregnant, and he wishes to assert his paternity for the possible child. He would complete the Notice of Intent to Claim Paternity form to register his assertion.

- A man and woman do not agree that he is the father of her child. The man wishes to assert his paternity.
- More than one man claims to be the father of the child. Each man would complete a separate Notice of Intent.
- The mother refuses to complete and sign the AOP form.
- The mother was married at or within 300 days before the child's birth and the mother and biological father cannot obtain a denial of paternity from her current or former husband.

Birth Worksheet for Child's Birth Certificate

This birth certificate worksheet is a tool to help your facility collect the necessary information for reporting births in TxEVER, the Texas Electronic Vital Events Registrar. Medical personnel should complete this worksheet. The information you report in TxEVER is used to create a child's birth certificate. Ensure the information you report is correct so that an accurate birth certificate is created. The birth certificate is a legal document that the child will use throughout their life to prove their identity, birthplace, and parentage. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Newborn			
Newborn Information			
Record Type: <input type="checkbox"/> Born at this facility <input type="checkbox"/> Born en-route to facility <input type="checkbox"/> Foundling/ Safe Haven <input type="checkbox"/> Home birth-Intended <input type="checkbox"/> Home birth-Intent unknown <input type="checkbox"/> Home birth-Unintended <input type="checkbox"/> Surrogacy-1 Parent <input type="checkbox"/> Surrogacy-2 Parent	Plurality: <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Quadruplets <input type="checkbox"/> Quintuplets <input type="checkbox"/> Sextuplets <input type="checkbox"/> Septuplets <input type="checkbox"/> Eight <input type="checkbox"/> Nine <input type="checkbox"/> Ten <input type="checkbox"/> Unknown	Birth Order: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth <input type="checkbox"/> Fifth <input type="checkbox"/> Sixth <input type="checkbox"/> Seventh <input type="checkbox"/> Eighth <input type="checkbox"/> Ninth <input type="checkbox"/> Tenth <input type="checkbox"/> Conjoined	Is Child Unnamed? <input type="checkbox"/> Yes <input type="checkbox"/> No
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth: ____ / ____ / _____	Time of Birth: __: __ <input type="checkbox"/> AM <input type="checkbox"/> PM	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/ Not yet Determined	Infant's Medical Record Number:
SSN Information			
Parents Authorize Release of Information to Social Security Administration to Issue this Child a SSN: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Mother's Information			
Title Preference: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Legal First Name:	Legal Middle Name:	Legal Last Name:
Legal Suffix:	Medical Record Number:		

Birth Worksheet for Child's Birth Certificate

Facility Information & Place of Birth

Name:		Facility Name Other (Specify):		Type:		Type Other Specify:	
<input type="checkbox"/> Facility Name: <input type="checkbox"/> Other				<input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Birth Intended <input type="checkbox"/> Home Birth Intent Unknown <input type="checkbox"/> Home Birth Unintended <input type="checkbox"/> Hospital <input type="checkbox"/> Licensed Birthing Center <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Address:			Apt:	State:		County:	
Local:		City/Town:		Zip:		Zip Ext:	

Mother

Mother's Name Prior to First Marriage

Same as Mother's Legal Name?

First Name:	Middle Name:	Last Name:	Suffix:
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Mother's Information

Date of Birth: / /	Age at Child's Birth:		
Birthplace: (Click Checkbox to Filter Foreign Countries Only)	SSN:		
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Married, Husband Info Refused <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Not Stated/Unknown	Married Within 300 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but refusing presumed father information <input type="checkbox"/> Unknown		
AOP Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes - Common Law	Date Acknowledgement of Paternity Signed:		
Did Mother Relinquish Rights to Child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mother's Relinquish Date: / /		
Paternity Genetic Testing? <input type="checkbox"/> Not done <input type="checkbox"/> Has Determined Biological Father			

Birth Worksheet for Child's Birth Certificate

Mother's Miscellaneous Information

Education Level:

- 8th Grade or Less
- 9th-12th Grade No Diploma
- High School Graduate or GED Completed
- Some College Credit, No Degree
- Associate Degree (E.G., AA, AS)
- Bachelor's Degree (BA, AB, BS)
- Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- Unknown/Not stated

Occupation:

Kind of Business or Industry:

Email:

Mother's Residence Address Information

- Withheld by Request on AOP

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Inside City Limits:

- Yes No Unknown

Mother's Mailing Address Information

- Same as Residence?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Mother Demographics

Mother's Ethnicity

- No, Not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other Hispanic (Specify: _____)
- Unknown

Birth Worksheet for Child's Birth Certificate

Mother's Race

- White
- Black or African American
- American Indian or Alaska Native (Name of the Enrolled or Principal Tribe: _____)
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (Specify: _____)
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (Specify: _____)
- Other (Specify: _____)
- Unknown

Father

Father's Legal Name

Title Preference: Mother Father Parent

First Name:	Middle Name:	Last Name:	Suffix:
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Father's Maiden Name

Same as Father's Legal Name?

First Name:	Middle Name:	Last Name:	Suffix:
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Father's Information

Date of Birth: __/__/____	Age:
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Birthplace: (Click Checkbox to Filter Foreign Countries Only)	SSN: ____-____-_____
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Birth Worksheet for Child's Birth Certificate

Father's Miscellaneous Information

Education Level:

- 8th Grade or Less
- 9th-12th Grade No Diploma
- High School Graduate or GED Completed
- Some College Credit, No Degree
- Associate Degree (E.G., AA, AS)
- Bachelor's Degree (BA, AB, BS)
- Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- Unknown/Not stated

Occupation:

Kind of Business or Industry:

Father's Mailing Address Information

Withheld by Request on AOP

Same as Mother's Mailing?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Birth Worksheet for Child's Birth Certificate

Father Demographics	
Father's Ethnicity	Father's Race
<input type="checkbox"/> No, Not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Other Hispanic (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> American Indian or Alaska Native (Name of the Enrolled or Principal Tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused

This tab displays when AOP = yes on Mother's Tab and marital status = yes

Presumed Father			
Presumed Father's Legal Name			
First Name:	Middle Name:	Last Name:	Suffix:
Presumed Father's Information			
Date of Birth: ____/____/____		SSN: ____ - ____ - _____	
Presumed Father's Mailing Address Information			
<input type="checkbox"/> Withheld by Request on AOP		<input type="checkbox"/> Same as Mother's Mailing?	
Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:



Birth Worksheet for Child's Birth Certificate

This tab displays when record type = surrogacy 1 parent/surrogacy 2 parent

Intended Mother			
Intended Mother's Current Legal Name			
Title Preference: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent			
First Name:	Middle Name:	Last Name:	Suffix:
Intended Mother's Name Prior to First Marriage			
Same as Intended Mother's Legal Name? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First Name:	Middle Name:	Last Name:	Suffix:
Mother's Information			
Date of Birth: ___/___/_____	Age:	Birthplace: (Click Checkbox to Filter Foreign Countries Only)	
SSN:			
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Married, Husband Info Refused <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Not Stated/Unknown			
Intended Mother's Medicaid Information			
Intended Mothers Medicaid Chip Name:		Intended Mothers Medicaid Chip Number:	
Intended Mother's Residence Address Information			
Address:	Apt:	State/Country:	County:
City/Town:	Zip:	Zip Ext:	Inside City Limits:
Intended Mother's Mailing Address Information			
<input type="checkbox"/> Same as Residence?			
Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:



Birth Worksheet for Child's Birth Certificate

Intended Father			
Intended Father's Legal Name			
Title Preference: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent			
First Name:	Middle Name:	Last Name:	Suffix:
Father's Maiden Name			
Same as Intended Father's Legal Name? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First Name:	Middle Name:	Last Name:	Suffix:
Intended Father's Information			
Date of Birth: ____ / ____ / ____	Age:	Birthplace (Click Checkbox to Filter Foreign Countries Only):	SSN:

Mother Medical - 1	
General	
Mother Transferred for Delivery? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, from What Location: <input type="checkbox"/> OTHER (Option to Search All Locations Available in TxEVER)
Mother Transfer Facility - Other:	
Principal Source of Payment: <input type="checkbox"/> PRIVATE INSURANCE (BLUE CROSS/ BLUE SHIELD, AETNA, ETC.) <input type="checkbox"/> MEDICAID/CHIP (PENDING OR NOT) <input type="checkbox"/> SELF PAY <input type="checkbox"/> OTHER <input type="checkbox"/> INDIAN HEALTH SERVICE <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> OTHER GOVERNMENT (FEDERAL, STATE, LOCAL)	
Principal Source of Payment - Other (Specify):	
Did Mother Get WIC Food for Herself during This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother's Medicaid Chip Name:	Mother's Medicaid Chip Number:



Birth Worksheet for Child's Birth Certificate

Cigarettes Information

Did Mother Smoke Cigarettes before or during Pregnancy? Yes No

Did Mother Report in Packs?

Did Mother Report in Cigarettes?

	# of Cigarettes Per Day	# of Packs Per Day
Three Months before Pregnancy		
First Trimester		
Second Trimester		
Third Trimester		

Mother's Health Information

Mother's Weight at Delivery (lbs):	Mother's Pre-Pregnancy Weight (lbs):
Mother's Height (Feet/Inches):	Date Last Normal Menses Began:

HIV Testing

HIV Test Done Prenatally? Yes No Unknown

Check All that Apply:

- First Trimester
- Second Trimester
- Third Trimester
- None
- Unknown

HIV Test Done at Delivery? Yes No Unknown

Infant Tested for HIV at Birth? Yes No Unknown

Birth Worksheet for Child's Birth Certificate

Mother Medical – 2

Pregnancy History

Number of Previous Live Births Now Living (Do Not Include This Child):

Number of Previous Live Births Now Dead:

Date of Last Live Birth: ____ / ____ / ____ Number of Other Pregnancy Outcomes:

Date of Last Other Pregnancy Outcome: ____ / ____ / ____

Prenatal

Did Mother Receive Prenatal Care? Yes No Unknown

Date of First Prenatal Care Visit: ____ / ____ / ____

Date of Last Prenatal Care Visit: ____ / ____ / ____

Total Number of Prenatal Care Visits; If None, Enter '0':

Source of Prenatal Care Visits

- Hospital
- Public Health Clinic
- Private Physician
- Midwife
- Other: Specify
- None
- Unknown
 - MVR (Missing Value Reason)
 - Refused
 - Not Obtainable
 - Sought But Not Obtainable

Method of Delivery

Was Delivery with Forceps Attempted but Unsuccessful? Yes No

Was Delivery with Vacuum Extraction Attempted but Unsuccessful? Yes No

Fetal Presentation at Birth?

- Cephalic
- Breech
- Other

Final Route & Method of Delivery?

- Vaginal/Spontaneous
- Vaginal/Forceps
- Vaginal/Vacuum
- Cesarean (Final Route)
- Unknown

If Cesarean, Was a Trial of Labor Attempted? Yes No

Mother Medical - 3

Exposure/Infections Present/Treated During Pregnancy

Exposure/Infections Present/Treated during Pregnancy (Check All that Apply):

- Gonorrhea
- Syphilis
- Chlamydia
- Hepatitis B
- Hepatitis C
- Unknown
- Infection MVR:
 - Refused
 - Not Obtainable
 - Sought, But Not Obtainable
- None of the Above

Risk Factor in this Pregnancy

Risk Factors in this Pregnancy (Check All that Apply):

- Diabetes (Select One of the Following)
 - Pre-Pregnancy (Diagnosis Prior to this Pregnancy)
 - Gestational (Diagnosis in this Pregnancy)
- Hypertension (Select One of the Following)
 - Pre-Pregnancy (Chronic)
 - Gestational (PIH, Preeclampsia)
 - Eclampsia
- Previous Preterm Birth
- Other Previous Poor Pregnancy Outcome (Includes Perinatal Death, Small for Gestational Age/Intrauterine Growth Restricted Birth)
 - Perinatal Death
 - Small for Gestational Age
 - Intrauterine Growth Restriction
 - Other (Specify) _____
- Pregnancy Resulted from Infertility Treatment (Check All that Apply):
 - Fertility-Enhancing Drugs
 - Artificial Insemination
 - Intrauterine Insemination
 - Assisted Reproductive Technology - Vitro Fertilization (IVF)
 - Assisted Reproductive Technology - Gamete Intrafallopian Transfer (GIFT)
 - Other (Specify) _____
- Mother Had a Previous Cesarean Delivery?
 - If selected, how many? _____
- Antiretrovirals Administered during Pregnancy or at Delivery
- Cholecystitis
- Prior Classical Cesarean
- Prior Myomectomy
- None of the Above
- Unknown (Select One)
 - Refused
 - Not Obtainable
 - Sought, But Not Obtainable

Birth Worksheet for Child's Birth Certificate

Mother Medical – 4	
Obstetric Procedures	Onset of Labor
<p>Obstetric Procedures (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cervical Cerclage <input type="checkbox"/> External Cephalic Version (choose one): <ul style="list-style-type: none"> <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> Tocolysis <input type="checkbox"/> None of the Above 	<p>Onset of Labor (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Premature Rupture of the Membranes (Prolonged > 18 Hours) <input type="checkbox"/> Precipitous Labor (Less than 3 Hours) <input type="checkbox"/> Prolonged Labor (Greater than 20 Hours) <input type="checkbox"/> None of the Above <input type="checkbox"/> Unknown <ul style="list-style-type: none"> <input type="checkbox"/> Refused <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Sought But Not Obtainable
Characteristics of Labor & Delivery	Maternal Morbidity
<p>Characteristics of Labor & Delivery (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Induction of Labor <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Non-Vertex Presentation <input type="checkbox"/> Steroids (Glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery <input type="checkbox"/> Antibiotics Received by Mother during Labor <input type="checkbox"/> Clinical Chorioamnionitis Diagnosed during Labor or Maternal Temperature is > 38 C (100.4 F) <input type="checkbox"/> Moderate/Heavy Meconium Staining of the Amniotic Fluid <input type="checkbox"/> Fetal Intolerance of Labor Such That One of More of the Following Action Was Taken: In-Utero Resuscitative Measures, Further Fetal Assessment, or Operative Delivery <input type="checkbox"/> Epidural or Spinal Anesthesia during Labor <input type="checkbox"/> None of the Above <ul style="list-style-type: none"> <input type="checkbox"/> Other Complication Not Listed <input type="checkbox"/> No Complications Determined 	<p>Complication Associated with Labor and Delivery (Check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Third or Fourth Degree Perineal Laceration <input type="checkbox"/> Ruptured Uterus <input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admission to Intensive Care Unit <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <input type="checkbox"/> None of the Above

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 1

General

Is Infant Living at Time of Report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred, Status Unknown	Is Infant Being Breast Fed, Even Partially? <input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetric Estimate of Gestation (completed weeks):	
Apgar Score (at 5 min.): 1 - 10: <input type="checkbox"/> Not Taken <input type="checkbox"/> Unknown	Apgar Score (at 10 min.): 1 - 10: <input type="checkbox"/> Not Taken <input type="checkbox"/> Unknown
Was Infant Transferred within 24 Hours of Delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES Where:	
Infant Transfer Facility - Other:	Was Infant Vaccinated with Hepatitis B Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Information Unavailable
Infant Primary Care Physician:	

Child's Weight Information

Grams:	Pounds:	Ounces:
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ImmTrac Consent

Please Indicate the Parent's Choice Regarding Consent for ImmTrac Participation. The Birth Registrar Will be Required to Affirm that this Information Accurately Reflects the Parent's Choice.

If the Parent Has Not Yet Been Offered the Option to Consent for ImmTrac Participation, You May Skip this Section and Answer at a Later Time. This Section Must Be Completed for Legal Release of the Birth Registration.

- Parent Has GRANTED CONSENT for ImmTrac Participation by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT GRANTED Option.
- Parent Has DENIED CONSENT for ImmTrac Participation (Requested Exclusion) by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT DENIED Option.
- Parent Has Not Signed a Properly Completed DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2).

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 2

Abnormal Conditions	Congenital Anomalies
<p>Abnormal Conditions of Newborn (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted Ventilation Required Immediately Following Delivery <input type="checkbox"/> Assisted Ventilation Required for More than Six Hours <input type="checkbox"/> NICU Admission <input type="checkbox"/> Newborn Given Surfactant Replacement Therapy <input type="checkbox"/> Antibiotics Received by the Newborn for Suspected Neonatal Sepsis <input type="checkbox"/> Seizure or Serious Neurologic Dysfunction <input type="checkbox"/> Significant Birth Injury (Skeletal Fracture(s), Peripheral Nerve Injury, and/or Soft Tissue/Solid Organ Hemorrhage Requiring Intervention) <input type="checkbox"/> None of the Above 	<p>Congenital Anomalies (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina Bifida <input type="checkbox"/> Congenital Diaphragmatic Hernia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Down Syndrome: <ul style="list-style-type: none"> <input type="checkbox"/> Karyotype Confirmed <input type="checkbox"/> Karyotype Pending <input type="checkbox"/> Suspected Chromosomal Disorder: <ul style="list-style-type: none"> <input type="checkbox"/> Karyotype Confirmed <input type="checkbox"/> Karyotype Pending <input type="checkbox"/> Cleft Lip with Cleft Palate <input type="checkbox"/> Cleft Palate Alone <input type="checkbox"/> Cyanotic Congenital Heart Disease <input type="checkbox"/> Omphalocele <input type="checkbox"/> Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes) <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the Above

Certification

Attendant Information

First Name:	Middle Name:	Last Name:
Title: <input type="checkbox"/> MD <input type="checkbox"/> Midwife <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Attendant <input type="checkbox"/> Facility Administrator/Designee <input type="checkbox"/> Other	Other (Specify):	
Address:	Apt:	State/Country:
City/Town:	Zip:	Zip Ext:
NPI:	License Number:	

Birth Worksheet for Child's Birth Certificate

Certifier Information		
<input type="checkbox"/> Certifier Same as Attendant?		
First Name:	Middle Name:	Last Name:
Title: <input type="checkbox"/> MD <input type="checkbox"/> Midwife <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Attendant <input type="checkbox"/> Facility Administrator/Designee <input type="checkbox"/> Other	Other (Specify):	
Address:	Apt:	State/Country:
City/Town:	Zip:	Zip Ext:
Date Certified:		



(Please print clearly)

Child's Last Name

Child's First Name

Child's Date of Birth

Mother's First Name

Mother's Street Address

City

Child's Middle Name

Child's Gender: Male Female

Mother's Maiden Name

Apartment # Telephone

State Zip Code County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac").

- a public health district or local health department for public health purposes within their areas of jurisdiction;
a physician or other health-care provider legally authorized to administer vaccines for treating the child as a patient;
a state agency having legal custody of the child;
a Texas school or child-care facility in which the child is enrolled;
a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group - MC 1946, P. O. Box 149347, Austin, Texas 78714 - 9347.

Please mark the appropriate box with a [X] to indicate your choice.

- I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.
I DENY consent for registration. I wish to EXCLUDE my child's information from the Texas immunization registry.

Parent, legal guardian, or managing conservator: Printed Name:

Date: Signature:

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request.

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider. Questions? (800) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2 Texas Department of State Health Services • ImmTrac2 Group - MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

BIRTH REGISTRARS

Please enter newborn client information in the Texas Electronic Registrar and affirm that consent has been granted. DO NOT fax to DSHS. Retain this form in the client's birth record.



ImmTrac2 Immunization Registry (RECIÉN NACIDO) FORMULARIO DE REGISTRO

(Favor de escribir claramente con letra de molde)

Grid for last name

Apellido del Niño(a)

Grid for first name

Nombre del Niño(a)

Grid for birth date

Fecha de Nacimiento del Niño(a)

*Solo recién nacidos.

Grid for second name

Segundo Nombre del Niño(a)

Género: [] Masculino [] Femenino

Grid for mother's name

Nombre de la Madre

Grid for mother's maiden name

Apellido de Soltera de la Madre

Grid for mother's address

Dirección de la Madre, Calle

Grid for apartment and phone

Apartamento # Teléfono

Grid for city

Ciudad

Grid for state, zip, and county

Estado Código Postal Condado

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menores de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac2. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud de Texas (DSHS) le anima a que participe voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac2 y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group - MC 1946, P. O. Box 149347, Austin, Texas 78714 - 9347.

Favor de marcar la caja [X] indicando la selección de su preferencia.

- [] YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño(a) en el registro de inmunización de Texas.
[] YO NIEGO el consentimiento para registrarlo. Deseo EXCLUIR la información de mi niño(a) del registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes:

Escriba con letra de molde

Fecha:

Firma:

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.texas.gov para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac2 del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (800) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2

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