CERTIFICATE OF LIVE BIRTH
FLORIDA

Screen Consent ___ Yes ___ No
Program Consent ___ Yes ___ No
Info. Release ___ Yes ___ No

Local File No. **109-**

CHILD

TYPE IN BLACK INK

1. CHILD'S NAME *(First, Middle, Last, Suffix)*
2. SEX
3. DATE OF BIRTH *(Month, Day, Year)*
4. BIRTH WEIGHT *(Enter lbs/ozs OR grams)* ________ lbs ________ ozs ________ grams
5. TIME OF BIRTH *(24 hr.)*
6. COUNTY OF BIRTH
7. 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)*
8. FACILITY NAME *(If not institution, give street and number)*
9. CITY, TOWN OR LOCATION OF BIRTH

CERTIFIER/ ATTENDANT

10. CERTIFIER'S SIGNATURE AND TITLE ___ M.D. ___ D.O. ___ C.N.M. ___ L.M. ___ Hosp. Admin. ___ Other *(Specify)*
►
11. DATE SIGNED *(Month, Day, Year)*
12. ATTENDANT'S NAME AND TITLE ___ M.D. ___ D.O. ___ C.N.M. ___ L.M. ___ Other *(Specify)*
13. DATE FILED BY REGISTRAR *(Month, Day, Year)* *(Reg.Initials)*

MOTHER / PARENT

14a. MOTHER'S/PARENT'S NAME *(First, Middle, Last, Suffix)*
14b. MOTHER'S/PARENT'S NAME PRIOR TO FIRST MARRIAGE (If applicable)
15. IS MOTHER/PARENT MARRIED? ______ Yes _____ No
16. MOTHER'S/PARENT'S DATE OF BIRTH *(Month, Day, Year)*
17. MOTHER'S/PARENT'S BIRTHPLACE *(State, Territory or Foreign Country)*
18a. MOTHER'S/PARENT'S RESIDENCE - STATE
18b. COUNTY
18c. CITY, TOWN OR LOCATION
18d. STREET AND NUMBER
18e. APT. NO.
18f. ZIP CODE
18g. INSIDE CITY LIMITS? _____ Yes _____ No
18h. MOTHER'S/PARENT'S MAILING ADDRESS ________ Check here if same as Residence, or

Street and Number:	Apt. No.	City:	State:	Zip Code:

FATHER / PARENT

19a. FATHER'S/PARENT'S NAME *(First, Middle, Last, Suffix)*
19b. FATHER'S/PARENT'S NAME PRIOR TO FIRST MARRIAGE (If applicable)
20. FATHER'S/PARENT'S DATE OF BIRTH *(Month, Day, Year)*
21. FATHER'S/PARENT'S BIRTHPLACE *(State, Territory or Foreign Country)*

PARENT

I certify that the personal information provided on this certificate is correct to the best of my knowledge.

22. SIGNATURE *of Parent* ►

PATERNITY ACKNOWLEDGEMENT

PATERNITY

23. FATHER'S ADDRESS

Street and Number:	Apt. No.	City:	State:	Zip Code:

WE HEREBY SWEAR OR AFFIRM THAT WE WERE NOT MARRIED AT THE TIME OF BIRTH, ARE THE NATURAL PARENTS OF THE CHILD NAMED HEREIN AND WE HAVE READ (OR HAVE HAD READ TO US) DH FORM 1568 AND UNDERSTAND THE RIGHTS AND RESPONSIBILITIES OF PARENTHOOD. WE ACKNOWLEDGE THAT IT IS A FELONY TO FURNISH FALSE INFORMATION ON THIS DOCUMENT.

(Father's Signature) (Date)

________ / ________
(Witness 1) (Witness 2)

STATE OF FLORIDA, COUNTY OF ________
SWORN TO OR AFFIRMED BY

(Print Father's Name)

IDENTIFIED BY: ________
(form and number of ID)

this ________ day of ________

Notary Public - State of Florida
my commission expires:

(Mother's Signature) (Date)

________ / ________
(Witness 1) (Witness 2)

STATE OF FLORIDA, COUNTY OF ________
SWORN TO OR AFFIRMED BY

(Print Mother's Name)

IDENTIFIED BY: ________
(form and number of ID)

this ________ day of ________

Notary Public - State of Florida
my commission expires:

FOR ADMINISTRATIVE USE ONLY

ADMIN

24. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ___ Yes ___ No
25a. MOTHER'S/PARENT'S SOCIAL SECURITY NUMBER
25b. FATHER'S/PARENT'S SOCIAL SECURITY NUMBER
26. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY ___ Medicaid ___ Private Insurance ___ Self-pay ___ Other *(Specify)*
27. DID MOTHER/PARENT GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ___ Yes ___ No
28a. WAS MOTHER/PARENT TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ___ Yes ___ No *(If Yes, specify name of facility transferred from)*
28b. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ___ Yes ___ No *(If Yes, specify name of facility transferred to)*
29a. IS INFANT LIVING AT TIME OF REPORT? *(If No, complete items 29b-29c)* ___ Yes ___ No ___ Infant transferred, status unknown
29b. DATE OF DEATH *(Month, Day, Year)*
29c. COUNTY OF DEATH

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER / PARENT

30. OF HISPANIC OR HAITIAN ORIGIN? *(Specify if mother/parent is of Hispanic or Haitian Origin.)*
____ Not of Hispanic/Haitian Origin ___ Unknown if Hispanic/Haitian Origin
Yes, of Hispanic/Haitian Origin *(Select one):* ___ Mexican ___ Puerto Rican ___ Cuban ___ Other Hispanic *(Specify)* ___ Haitian

31. RACE *(Specify the race/races to indicate what mother/parent considers themself to be. More than one race may be specified.)*
____ White ___ Black or African American ___ American Indian or Alaskan Native *(Specify tribe)*
____ Asian Indian ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Vietnamese ___ Other Asian *(Specify)*
____ Native Hawaiian ___ Guamanian or Chamorro ___ Samoan ___ Other Pacific Isl. *(Specify)* ___ Other *(Specify)*

32. EDUCATION *(Specify highest degree or level of school completed at time of delivery.)*
____ 8th or less ___ High school but no diploma ___ High school diploma or GED ___ College but no degree
College degree *(Specify):* ___ Associate ___ Bachelor's ___ Master's ___ Doctorate

FATHER / PARENT

33. OF HISPANIC OR HAITIAN ORIGIN? *(Specify if father/parent is of Hispanic or Haitian Origin.)*
____ Not of Hispanic/Haitian Origin ___ Unknown if Hispanic/Haitian Origin
Yes, of Hispanic/Haitian Origin *(Select one):* ___ Mexican ___ Puerto Rican ___ Cuban ___ Other Hispanic *(Specify)* ___ Haitian

34. RACE *(Specify the race/races to indicate what father/parent considers themself to be. More than one race may be specified.)*
____ White ___ Black or African American ___ American Indian or Alaskan Native *(Specify tribe)*
____ Asian Indian ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Vietnamese ___ Other Asian *(Specify)*
____ Native Hawaiian ___ Guamanian or Chamorro ___ Samoan ___ Other Pacific Isl. *(Specify)* ___ Other *(Specify)*

35. EDUCATION *(Specify highest degree or level of school completed at time of delivery.)*
____ 8th or less ___ High school but no diploma ___ High school diploma or GED ___ College but no degree
College degree *(Specify):* ___ Associate ___ Bachelor's ___ Master's ___ Doctorate

PREGNANCY HISTORY

36a. PRENATAL CARE RECEIVED?
____ Yes ___ No *(If No, skip to # 37)*

36b. DATE OF FIRST PRENATAL VISIT *(Mo, Day, Yr)*

36c. DATE OF LAST PRENATAL VISIT *(Mo, Day, Yr)*

36d. PRENATAL VISITS
Number ________

37. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

38. MOTHER'S/PARENT'S HEIGHT
____________ feet/inches

39a-b. MOTHER'S/PARENT'S WEIGHT (*in pounds*)
__________ prepregnancy ______________ at delivery

40. 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	________
Third Trimester of Pregnancy	________	OR	________

41. ALCOHOL USE DURING PREGNANCY?
______ Yes ______ No

42a-b. PREVIOUS LIVE BIRTHS *(Do not include this child)*
Number Now Living ______ Number Now Dead ______

42c. DATE OF LAST LIVE BIRTH *(Month, Year)*

42d. OTHER PREGNANCY OUTCOMES
(Spontaneous or induced losses, or ectopic pregnancies)
Total Number ________

42e. DATE OF LAST OTHER OUTCOME *(Month, Ye*

MEDICAL AND HEALTH INFORMATION

43. RISK FACTORS IN THIS PREGNANCY *(Check all that apply)*
____ Diabetes - Prepregnancy (Diagnosis prior to this pregnancy) ___ Diabetes - Gestational (Diagnosis in this pregnancy)
____ Hypertension - Prepregnancy (Chronic) ___ Hypertension - Gestational (PIH, preeclampsia) ___ Hypertension - Eclampsia
____ Previous preterm birth ___ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
____ Mother/Parent had a previous cesarean delivery (If yes, how many ____)
____ Pregnancy resulted from infertility treatment (If yes, check all below that apply)
___ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
___ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
____ Other *(Specify)* ___ None

44. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY *(Check all that apply)*
____ Gonorrhea ___ Syphilis ___ Chlamydia ___ Hepatitis B ____ Hepatitis C
____ Other *(Specify)* ___ None

45. OBSTETRIC PROCEDURES *(Check all that apply)*
____ Cervical cerclage ___ External cephalic version *(Successful)* ___ External cephalic version *(Failed)*
____ Other *(Specify)* ___ None

46. ONSET OF LABOR *(Check all that apply)*
____ Premature Rupture of the Membranes *(prolonged, $\geq$ 12 hrs.)* ___ Precipitous Labor *(< 3 hrs.)* ___ Prolonged Labor *($\geq$ 20 hrs.)*
____ Other *(Specify)* ___ None

47. CHARACTERISTICS OF LABOR AND DELIVERY *(Check all that apply)*
____ Induction of labor ___ Augmentation of labor ___ Steroids (glucocorticoids) for fetal lung maturation received by the mother/parent prior to delivery
____ Antibiotics received by the mother/parent during labor ___ Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38^{0}C (100.4^{0}F)
____ 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
____ Epidural or spinal anesthesia during labor
____ Other *(Specify)* ___ None

48. METHOD OF DELIVERY
A. Fetal presentation at birth: ___ Cephalic ___ Breech ___ Other *(Specify)*
B. Final route and method of delivery *(Check one):* ___ Vaginal/Spontaneous ___ Vaginal/Forceps ___ Vaginal/Vacuum
___ Cesarean *(Was a trial of labor attempted? _____ Yes _____ No)*

S. E. #

49. MATERNAL MORBIDITY *(Complications associated with labor and delivery)* *(Check all that apply)*
____ Maternal transfusion ___ Third or fourth degree perineal laceration ___ Ruptured uterus ___ Unplanned hysterectomy ___ Admission to intensive care unit
____ Unplanned operating room procedure following delivery ___ Other *(Specify)* ___ None

NEWBORN

50. OBSTETRIC ESTIMATE OF GESTATION
_________ completed weeks

51a. PLURALITY *(Single, Twin, etc.)*

51b. IF NOT SINGLE BIRTH *(Born First, Second, etc.)*

52. WAS INFANT BEING BREASTFED DURING THE PERIOD BETWEEN BIRTH AND DISCHARGE FROM THE HOSPITAL? ______ Yes ______ No

53. APGAR SCORE
______ 5 min. ______ 10 min. *(If 5 min. score < 6)* ______ Not done

54. ABNORMAL CONDITIONS *(Check all that apply)*
____ Assisted ventilation required *(immediately following delivery)* ___ Assisted ventilation required *($\geq$ 30 min.)* ___ Assisted ventilation required *($\geq$ 6 hrs.)*
____ NICU Admission ___ Newborn given surfactant replacement therapy
____ Antibiotics received by the newborn for suspected neonatal sepsis ___ Seizure or serious neurologic dysfunction
____ Significant birth injury *(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)*
____ Hyaline Membrane Disease/RDS ___ Other *(Specify)* ___ None

55. CONGENITAL ANOMALIES *(Check all that apply)*
____ Anencephaly ___ Meningomyelocele/Spina bifida ___ Cyanotic congenital heart disease ___ Congenital diaphragmatic hernia
____ Omphalocele ___ Gastroschisis ___ Limb reduction defect *(excluding congenital amputation and dwarfing syndromes)*
____ Cleft Lip with or without Cleft Palate ___ Cleft Palate alone
____ Down Syndrome *(Karotype: _____confirmed _____ pending)* ___ Suspected chromosomal disorder *(Karotype: _____confirmed _____ pending)*
____ Hypospadias ___ Other *(Specify)* ___ None

56. MOTHER'S/PARENT'S MEDICAL RECORD NUMBER

57. NEWBORN MEDICAL RECORD NUMBER

State of Florida • Department of Health • Vital Statistics