Baby's Birth Certificate Application

PLEASE READ THE FRONT AND BACK BEFORE YOU BEGIN TO COMPLETE THE APPLICATION

Please complete this application as soon as possible and give it to your nurse. The Birth Registrar's office does not process any birth certificates after 2:00 pm.

Only the mother or father should complete this application. We understand there may be certain circumstances where the grandparents need to help.

Please take only this top sheet home with you and do not take the application. Without it, we cannot process your baby's birth certificate application and you will have to go to the Health Department for the complete process.

Seven days after the submission of the birth certificate application, you can purchase a certified copy of the Birth Certificate from the Chatham Co. Health Dept. at 1395 Eisenhower Drive **(912-356-2138).** The cost is **$25** and additional copies are **$5 each** at time of purchase. You may also visit any County Vital Records Dept. in Georgia to obtain a copy of the Certificate.

If you have any questions, please call The Birth Registrar at 912.819.6389

THE HOSPITAL DOES NOT ISSUE BIRTH CERTIFICATES

Mary Telfair Women's Hospital

Congratulations on the birth of your child!

The Certificate of Live Birth for your newborn is a very important document, therefore, it is essential that the information and the names shown on the record are all entered accurately and correctly spelled. Be sure that you furnish the correct spelling of the parent's complete name and the child's complete name to the hospital birth records clerk. If you don't speak English well, please request an interpreter. Closely review the information entered and make any corrections before the certificate is submitted.

It is understood that some people of Latin heritage have the custom of giving both the paternal and maternal last names (surnames) to their newborn. This may be done in some instances, but there are Georgia laws that you should know about that govern giving or changing the name of a child. The order of the surname is important as it effects the documents you obtain for Passports and Visas to exit or enter your country of origin.

For a child conceived by, or born to a married couple, Georgia law (Section 31-10-9) allows the full name of the child to be selected by the mother, including hyphenated last names.

For a child born to a mother who was unmarried during the pregnancy or at the time of birth, and no paternity acknowledgment is completed, the mother's legal last name must be entered on the birth certificate as the child's last name. Georgia law allows no other alternative in this situation.

For an out-of-wedlock birth, and a paternity acknowledgment is completed, the parents can select any name for the child. (A married couple cannot complete a paternity acknowledgment for their child born in wedlock).

In all cases, once the birth record has been registered by the hospital with Vital Records, hospital staff cannot make changes to the certificate. After registration, changing or amending the child's last name (surname) or the parents' given or last name (surname) can ONLY be done by a court order from a Superior or Probate court.

Georgia Department of Human Resources Rule 290-1-3-.27 allows the parents to amend the child's first and middle name(s) during the first year of life without charge by an affidavit signed by both parents. However, if a paternity acknowledgment was previously completed, no further amendment to the child's name can be made except by a court order from a Superior or Probate Court.

If you have questions about naming, changing the name of your child, paternity acknowledgment, or amending a birth certificate, please call Vital Records at 404.679.4702.

Georgia Vital Records/DPH/DHR

STATE OF GEORGIA
BIRTH WORKSHEET

NEWBORN - DEMOGRAPHIC

1. THIS BIRTH (Single, Twin, Triplet, etc)	2. IF NOT SINGLE, SPECIFY (1st, 2nd, 3rd, 4th, etc.)

3. NEWBORN'S NAME (FIRST MIDDLE LAST SUFFIX)	4. DATE OF BIRTH (mm/dd/yyyy)	5. TIME OF BIRTH (24 hr)	6. SEX

7. HOSPITAL FACILITY NAME AND ADDRESS (if not Hospital, give street and number)	8. CITY, TOWN OR LOCATION OF BIRTH	9. FACILITY ID (NPI)
❑Hospital ❑Birthing Center ❑Enroute/BOA ❑Clinic/Doctor's Office ❑ER ❑Other (specify)_____		

10. SPECIFY BIRTHPLACE	11. COUNTY, STATE AND ZIP CODE OF BIRTH

MOTHER - DEMOGRAPHIC

12. MOTHER'S NAME (FIRST MIDDLE LAST)	13. NAME PRIOR TO FIRST MARRIAGE (FIRST MIDDLE LAST)

14. DATE OF BIRTH (mm/dd/yyyy)	15. BIRTHPLACE (State, Territory or Foreign Country)	16. MOTHER'S SSN

17a. MOTHER'S MARITAL STATUS Married at the time of conception or time of birth? ❑Yes ❑No ❑Unknown
If not married, has an order of paternity or legitimation been issued by a court? ❑Yes ❑No ❑Unknown
Have both mother and father consented in writing to have father's name on the certification or have they both signed a paternity acknowledgment? ❑Yes ❑No ❑Unknown

17b. DATE PATERNITY ACKNOWLEDGMENT OR LEGITIMATION SIGNED (mm/dd/yyyy)

18. NUMBER AND STREET OF RESIDENCE	19. CITY, TOWN OR LOCATION	20. RESIDENCE STATE
Phone Number: _____ Residing at current residence for: ___ Years ___ Months	Inside city limits? ❑Yes ❑No ❑Unknown	

21. COUNTY OF RESIDENCE	22. ZIP CODE	23. MOTHER'S MAILING ADDRESS (Street, City, State, Zip, County) ❑ Mailing address same as above

24. MOTHER'S EDUCATION LEVEL (Choose **only one** option that represents the highest level of education attained)

❑Completed 1st Grade ❑Completed 2nd Grade ❑Completed 3rd Grade ❑Completed 4th Grade ❑Completed 5th Grade ❑Completed 6th Grade
❑Completed 7th Grade ❑Completed 8th Grade ❑Completed 9th Grade ❑Completed 10th Grade ❑Completed 11th Grade
❑Completed 12th Grade but Did NOT Graduate ❑High school graduate or GED

❑Some college credit leading to an Associate degree but did **NOT** Graduate ❑Associate degree (e.g. AA, AS) ❑Bachelor's degree (e.g. BA, BS)
❑Some college credit leading to a Bachelor's degree but did **NOT** Graduate ❑Master's degree (e.g. MA, MS) ❑Doctorate (e.g. PhD, EdD, MD)
❑None ❑Unknown

25. Primary Language spoken at Home_____ **26.** Mother's Occupation_____

27. Kind of business or industry_____ **28.** Employed during last year ❑ Yes ❑ No ❑ Unknown

29. Employer's name/address:_____
Name Street City State/Country Zip Code

30. MOTHER'S ETHNICITY

❑ Yes, Cuban ❑ No, not Spanish/Hispanic/Latino ❑ Yes, Puerto Rican ❑Refused ❑ Yes, Mexican, American, Chicano ❑Unknown ❑ Yes, Other Hispanic (Specify)_____

31. MOTHER'S RACE (Check all that apply)

❑White ❑Chinese ❑Korean ❑Guamanian or Chamorro
❑Black or African American ❑Filipino ❑Vietnamese ❑Samoan
❑Asian Indian ❑Japanese ❑Native Hawaiian ❑Other (Specify)_____
❑Other Pacific Islander (Specify)_____ ❑Other Asian (Specify)_____
❑American Indian or Alaska Native; *Specify enrolled or principal tribe_____ ❑Refused ❑Unknown

FATHER

32. FATHER'S NAME (FIRST MIDDLE LAST SUFFIX)	33. DATE OF BIRTH (mm/dd/yyyy)	34. BIRTHPLACE (State, Territory or Foreign Country)

35. FATHER'S SSN	36. FATHER'S RESIDENCE ADDRESS (STREET CITY STATE ZIP COUNTY)
	❑ Address same as mother's residence address

FATHER - DEMOGRAPHIC

37. FATHER'S EDUCATION LEVEL (Check only one option that represents the highest level of education attained)

❑Completed 1st Grade ❑Completed 2nd Grade ❑Completed 3rd Grade ❑Completed 4th Grade ❑Completed 5th Grade ❑Completed 6th Grade
❑Completed 7th Grade ❑Completed 8th Grade ❑Completed 9th Grade ❑Completed 10th Grade ❑Completed 11th Grade
❑Completed 12th Grade but Did NOT Graduate ❑High school graduate or GED

❑Some college credit leading to an Associate degree but did **NOT** Graduate
❑Some college credit leading to a Bachelor's degree but did **NOT** Graduate
❑None
❑Associate degree (e.g. AA, AS)
❑Master's degree (e.g. MA, MS)
❑Unknown
❑Bachelor's degree (e.g. BA, BS)
❑Doctorate (e.g. PhD, EdD, MD)

38. Father's Occupation _____ **39.** Father's Industry _____ **40.** Employed during the last year? ❑ Yes ❑ No ❑ Unknown

41. Employer's Name and Address _____
Name Street & Number City State/Country Zip Code

42. FATHER'S ETHNICITY

❑ Yes, Cuban
❑ No, not Spanish/Hispanic/Latino
❑ Yes, Puerto Rican
❑Refused
❑ Yes, Mexican, American, Chicano
❑Unknown
❑ Yes, Other Hispanic (Specify)_____

43. FATHER'S RACE (Check all that apply)

❑White ❑Chinese ❑Korean ❑Guamanian or Chamorro
❑Black or African American ❑Filipino ❑Vietnamese ❑Samoan
❑Asian Indian ❑Japanese ❑Native Hawaiian ❑Other (Specify)_____
❑Other Pacific Islander (Specify)_____ ❑Other Asian (Specify)_____
❑American Indian or Alaska Native; *Specify enrolled or principal tribe_____ ❑Refused ❑Unknown

MOTHER - MEDICAL

44. Mother's Med Record #: _____ **45a.** Mother's pre-pregnancy weight: _____lbs ❑ Unknown **45b.** Mother's weight at delivery_____ lbs ❑ Unknown

46. Mother's height: ___ feet ___ inches ❑ Unknown **47.** Did Mother receive WIC during this pregnancy? ❑ Yes ❑ No ❑ Unknown

48a. Did mother use alcohol during pregnancy? ❑Yes ❑No ❑Unknown **48b.** How many drinks per week? _____

49. Did Mother smoke cigarettes before OR during this pregnancy ❑ Yes ❑ No ❑ Unknown
# of cigarettes _____ or # of packs _____three months before pregnancy # of cigarettes _____ or # of packs _____first trimester
# of cigarettes _____ or # of packs _____ second trimester # of cigarettes _____ or # of packs _____third trimester

50. Principle Source of Payment ❑ Tricare ❑ Medicaid ❑ Self Pay ❑ Other Government (Federal, State, Local) ❑ Indian Health Services
❑ Private Insurance ❑ Other _____ ❑ Unknown

51. Vaccinations during pregnancy (Note trimester) ❑TDAP Trimester _____ ❑ Flu Trimester _____ ❑ Other Trimester _____ ❑ None

52. MOTHER PREGNANCY HISTORY

a. Is this the mother's first pregnancy? ❑ Yes ❑ No ❑ Unknown
b. Number of previous live births now living_____ (Do not include this child)
c. Number of previous live births now dead _____

d. Date of last live birth ____/____/_____ (mm/dd/yyyy)
e. Number of fetal deaths less than 20 weeks (including ectopic loss, induced terminations or miscarriages) _____
f. Number of previous fetal deaths 20 weeks or greater (including induced terminations, miscarriages or stillbirths)_____

g. Date of last other pregnancy outcome ____/____/_____ (mm/dd/yyyy)

53. MOTHER PRENATAL CARE

a. Did mother receive prenatal care? ❑ Yes ❑ No ❑Unknown
b. Date of first prenatal care visit ____/____/_____ (mm/dd/yyyy)
c. Enter month prenatal care began _____ (1st, 2nd, 3rd month of pregnancy)
d. Date of last prenatal care visit ____/____/_____ (mm/dd/yyyy)
e. Total number of prenatal care visits _____ (If none, enter '0')
f. Date last normal menses began ____/____/_____ (mm/dd/yyyy)

54. Mother transferred for delivery? ❑ Yes ❑No If yes, from what location:_____

55. METHOD OF DELIVERY

a. Was delivery with forceps attempted but unsuccessful? ❑ Yes ❑ No ❑ Unknown

b. Was delivery with vacuum extraction attempted but unsuccessful? ❑Yes ❑ No ❑ Unknown

c. Fetal presentation at birth? ❑Cephalic ❑ Breech ❑ Other ❑ Unknown

d. Final route and method of delivery? ❑ Vaginal/spontaneous ❑ Vaginal/forceps ❑ Vaginal/vacuum ❑ Cesarean ❑ Unknown

e. If cesarean, was a trial labor attempted? ❑ Yes ❑ No ❑Unknown

56. EXPOSURE/INFECTIONS PRESENT/ TREATED DURING PREGNANCY (Check all that apply)

❑Bacterial Meningitis
❑Carrier/suspected carrier of viral hepatitis
❑Chemotherapy
❑Chlamydia
❑Congenital cytomegalovirus infection (CMV)
❑Congenital Rubella
❑Congenital Toxoplasmosis
❑Gonorrhea
❑Group B streptococcus
❑Hepatitis B
❑Hepatitis C
❑Herpes (active at the time of delivery)
❑HIV
❑Listeria
❑Parvovirus
❑Syphilis
❑Unknown
❑None of the above
❑Other (specify) _____

57. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

a. DIABETES (Select one of the following) ❑ Pre-pregnancy (diagnosis prior to this pregnancy) ❑Gestational (diagnosis in this pregnancy)

b. HYPERTENSION (Select one of the following) ❑ Pre-pregnancy (chronic) ❑ Gestational (PIH, preeclampsia) ❑ Eclampsia

c. ❑Previous preterm birth

d. Pregnancy resulted from infertility treatment (Check all that apply):

❑ Fertility enhancing drugs ❑Artificial insemination ❑ Intrauterine insemination
❑In vitro fertilization (IVF) ❑Gamete intrafallopian transfer (GIFT) ❑ Other (specify)_____

e. Other poor pregnancy outcome ❑Perinatal death ❑ Small for gestational age ❑Intrauterine growth restriction ❑ Other (specify)_____

f. ❑Mother had a previous cesarean delivery? If selected, how many?_____

g. ❑ None of the above

h. ❑ Unknown

58. OBSTETRIC PROCEDURES (Check all that apply)

❑ Cervical cerclage
❑ Tocolysis
❑ External cephalic version; ❑ Successful ❑ Failed
❑ None of the above
❑Unknown

59. ONSET OF LABOR (Check all that apply)

❑ Premature rupture of the membranes (prolonged > 18 hours)
❑ Precipitous labor (less than 3 hours)
❑ Prolonged labor (greater than 20 hours)
❑ None of the above
❑ Unknown

60. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

❑ Induction of labor
❑ Augmentation of labor
❑ Non-vertex presentation
❑ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery ❑Partial ❑ Complete
❑ Antibiotics received by mother during labor
❑ Clinical chorioamnionitis diagnosed during labor or maternal temperature is >38 C (100.4 F)
❑ Moderate/heavy meconium staining of the amniotic fluid
❑ 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
❑ None of the above
❑ Unknown

61. MATERNAL MORBIDITY (Check all that apply)

❑ Maternal transfusion
Number of units ❑1 ❑ 2 ❑3 or more
❑ Third or fourth degree perineal laceration
❑ Ruptured uterus
❑ Unplanned hysterectomy
❑ Admission to intensive care unit
❑ Unplanned operating room procedure following delivery
❑ None of the above
❑ Unknown

MOTHER - MEDICAL

62. Infant's Medical Record #_____

63. OB Estimated Gestation (completed weeks) _____ ❑Unknown

64a. Apgar score (at 5 min) _____ ❑Unknown

64b. Apgar score (at 10 min) _____ ❑ Unknown

65. Was infant transferred within 24 hours of delivery? ❑Yes ❑No ❑Unknown If yes, where? _____

66. Is infant living at time of report? ❑Yes ❑No ❑ Unknown

67. Is infant being breast fed, even partially? ❑Yes ❑No ❑ Unknown

68a. Weight Unit ❑Grams ❑Pounds ❑Unknown

68b. Weight Grams _____ Pounds ____ Ounces____ ❑Unknown

NEWBORN - MEDICAL

NEWBORN - MEDICAL

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

❑Assisted ventilation required immediately following delivery
❑Assisted ventilation required for more than six hours
❑NICU admission
❑Newborn given surfactant replacement therapy
❑Culture Positive Postnatal (Blood, CSF or other sources)
❑Antibiotics received by 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 requiring intervention)
❑None of the above
❑Unknown

70. CONGENITAL ANAMOLIES OF THE NEWBORN (Check all that apply)

❑ Anencephaly
❑Microcephaly
❑Meningomyelocele/Spina bifida
❑Cleft lip with cleft palate ❑Cleft lip alone ❑Cleft palate alone
❑Craniofacial anomalies
❑Cyanotic congenital heart disease
❑Congenital diaphragmatic hernia
❑Omphalocele
❑Gastroschisis
❑Limb reduction defect (not congenital amputation/dwarfing syndromes)
❑Down Syndrome (Karyotype ❑ Confirmed ❑ Pending)
❑Syndromes associated with hearing loss (neurofibromatosis, osteopetrosis, Usher, Waardneburg, Alport, Pendred, and Jervell and Lange-Nielson)
❑Suspected chromosomal disorder (Karyotype ❑ Confirmed ❑ Pending)
❑Hypospadias
❑None of the above
❑Other (specify) _____

71. OTHER EXPOSURES/CONDITIONS PRESENT IN UTERO OR POSTNATAL (Check all that apply)

❑Caregiver concern related to hearing loss
❑Congenital Hypothyroidism
❑Drug Withdrawal Syndrome in Newborn
❑Drug Use/Abuse/Withdrawal Syndrome in Mother
❑Encephalitis
❑Exposure to ototoxic medications or loop diuretics
❑Extracorporeal Membrane Oxygenation (ECMO) or Assisted Mechanical Ventilation >48 hours
❑Fetal Growth Restriction (IUGR)
❑Head Trauma
❑History of Positive Drug Screen (newborn)
❑HIV Present in Infant
❑Hydrocephaly
❑Hyperbilirubinemia requiring exchange transfusion
❑Intraventricular Hemorrhage (IVH), Grade III or IV
❑Neonatal intensive care of > 5 days
❑Neurodegenerative disorders
❑Neuromuscular Disorder
❑Neonatal jaundice d/t hepatocellular damage
❑Stage III necrotizing enterocolitis in newborn
❑None of the above
❑Other (specify)_____

72. HEPATITIS VACCINATION

a. Did the infant receive Hepatitis B vaccine? ❑ Yes ❑ No ❑ Unknown ❑ Refused
b. If infant received Hepatitis B vaccine, number of hours after birth _____
c. Did the infant receive Hepatitis B Immune Globulin (HBIG)? ❑ Yes ❑ No ❑Unknown
d. If infant received HBIG, number of hours after birth _____
e. Hepatitis B vaccine Date_____
f. Hepatitis B vaccine Lot Number _____
g. HBIG Lot Number_____

73. NEWBORN SCREENING

a. Was a metabolic screening performed for this infant? ❑ Yes ❑ No – Missed (transferred) ❑ No – Parent refusal ❑ No – Other _____ ❑ Unknown

b. Newborn Metabolic screening number _____

c. Was Hearing Screening performed for this infant? ❑Yes ❑Unable to screen in NICU ❑No - Missed (transfer) ❑No - missed (equipment down) ❑No - parent refusal ❑No - Missed (Other reason)_____ ❑Unknown

d. Final Hearing Screening Completed Date____/____/_____ (mm/dd/yyyy) ❑Unknown

e. Final Hearing Screening Right Ear Result ❑Pass ❑Refer ❑Unknown ❑Unable to test

f. Final Hearing Screening Left Ear Result ❑Pass ❑Refer ❑Unknown ❑Unable to test

g. Family History of Permanent childhood hearing loss? ❑Yes ❑No ❑Unknown

h. Final Newborn Hearing Test Type (select one) ❑AABR ❑ AOAE ❑AABR and AOAE

CERTIFIER

74. INFORMANT'S NAME (FIRST MIDDLE LAST)

75. RELATION TO CHILD

76. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINITRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER. ❑Yes ❑No

77. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)

78. DATE CERTIFIED (mm/dd/yyyy)

79. ATTENDANT AT BIRTH (OTHER THAN CERTIFIER (Name and Title))

❑MD ❑DO ❑Hospital Staff ❑ CMN/CM ❑Other Midwife ❑Other

80. CERTIFIER (Name and Title) ❑Certifier same as Attendant

❑MD ❑DO ❑Hospital Staff ❑ CMN/CM ❑Other Midwife ❑Other

81. PHYSICIAN'S MEDICAL LICENSE NO.

82. CERTIFIER'S MAILING ADDRESS (street, city, state, zip)

83. REGISTRAR (Signature)

84. DATE RECEIVED BY STATE REGISTRAR (mm/dd/yyyy)