Keeping Connecticut Healthy

DPH

Connecticut Department of Public Health

Registration of a Home Birth

Parent's Guide

Prepared by
State of Connecticut
Department of Public Health
Vital Records Unit

Rev. 01/2022 (Updated 4/2025)

CONGRATULATIONS ON THE BIRTH OF YOUR BABY!

The State of Connecticut wishes to make the filing of your home birth an easy task. There is information that you will need to provide to the Registrar of Vital Records *in the town in which your child was born* in order to register this birth. This booklet will detail the information required for filing this birth event with the town of birth.

The State of Connecticut requires that the birth worksheets be completed immediately following the birth. The parent(s) is responsible for completing the demographic **BIRTH PARENT'S WORKSHEET FOR CHILD BIRTH CERTIFICATE (v2003).**

The **Medical Data Worksheet for the Live Birth Certificate (v2003)** is completed by:

a) the attending practitioner in attendance at or immediately after the birth, or in the absence of such a person;
b) the birth parent, the non-birth parent, or in the absence of the non-birth parent and the inability of the birth parent;
c) any other person in attendance at or immediately after the birth.

The birth must be filed with the Registrar of Vital Records in the town in which the child was born not later than ten days after the birth. Prior to the preparation and filing of the birth certificate, the parent(s) need to provide the town Registrar of Vital Records with documentation to prove both pregnancy and birth.

Affidavit forms are provided in this packet for you to establish proof of pregnancy and proof of birth. They must be completed and signed in front of a Notary Public.

If birth parent and non-birth parent are not married, an Acknowledgment of Parentage form must be completed and signed by the birth parent and the non-birth parent before the non-birth parent's information can be placed on the birth certificate. This form is available from the Department of Public Health.

The State of Connecticut Department of Public Health works in coordination with the Social Security Administration to provide the opportunity for parents to secure a Social Security Number for their newborn. If you would like to have this service provided then read, complete, and sign the form entitled Social Security Number for Newborns, which is provided in this packet.

Also included in this packet is the CT-WiZ handout from the CT DPH Immunization program. CT-WiZ is a registry that maintains a permanent record of your child's immunizations for you and your pediatrician.

In addition, at the time of registration, the Registrar will also request to be provided with proof of residency and with photographic identification. Please refer to the list of acceptable documents.

REQUIRED DOCUMENTATION

The following list details the documentation that you need to provide to the Registrar of Vital Records in order to properly file your home birth. *Please keep in mind that the Registrar has the authority and responsibility to determine that the evidence presented is authentic and true.*

Proof of Pregnancy

(**ONE** of the following must be provided):

A. Signed and dated report from physician, clinic, or CT licensed midwife that provided prenatal care to the birth parent (this report must be made on physician, clinic, or midwife's letterhead stationery),

-OR-

B. Notarized affidavits from **two adults,** other than the birth parent or the non-birth parent, having firsthand knowledge of the pregnancy,

-OR-

C. A signed and dated report from a practitioner or clinic that provided postpartum care to the birth parent within twenty-four hours after the birth (this report must be made on physician or clinic letterhead stationery).

Proof of Birth

(**ALL** of the following are required)

A. A notarized affidavit by the birth parent attesting to the date, time, and place of the live birth **as well as notarized affidavits from all adult witnesses to this birth,**

-AND-

B. A signed and dated report from either the physician or clinic providing medical care to the newborn within 24 hours after the birth, or documentation of the earliest date of medical care given to the infant.

Proof of Residency	Proof of Identity

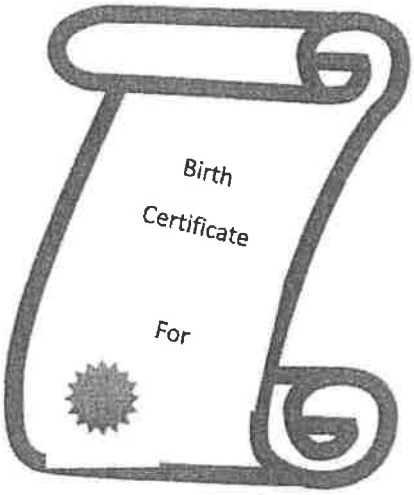
(**One** of the following may be submitted)
• Mortgage statement or lease agreement which includes birth parent's name and address
• Utility bill showing birth parent's name and address
• Birth parent's Driver's license
• Automobile registration showing birth parent's name and address
• Checking account deposit slip showing birth parent's name and address
• Birth parent's Voter Registration card
• State issued identification card which includes birth parent's residency
• Any additional form of documentation deemed necessary by the Registrar of Vital Records
	• Government issued photographic identification, or if a photo ID is not available, at least two of the following:
	  • Social Security card
	  • Automobile registration
	  • Utility bill showing name and address
	  • Checking account deposit slip showing name and address
	  • Voter registration card
	  • Written verification of identity from employer

PARENT'S CHECKLIST

Did you remember to provide the following information?

- ❑ Proof of Pregnancy Documentation
- ❑ Proof of Birth Documentation
- ❑ Proof of Residency
- ❑ Proof of Identity
- ❑ Completed Birth Parent's Worksheet For Child Birth Certificate (v2003)
- ❑ Completed Medical Data Worksheet for the Live Birth Certificate
- ❑ Completed Acknowledgment of Parentage form (if applicable)
- ❑ Completed Social Security Number for Newborns form
- ❑ Completed Connecticut Higher Education Trust (CHET) (online)

USES OF BIRTH CERTIFICATES



Some of the most common uses of birth certificates are:

1. Establishing the date of birth and age for purposes, such as:
   - entering school
   - obtaining a driver's license
   - proving age for work for minors
   - proving sports eligibility for minors
   - proving age of majority or minority in court cases

2. Establishing a birthplace to prove citizenship for purposes, such as:
   - obtaining a passport
   - entering employment limited to citizens
   - obtaining licenses limited to citizens

3. Establishing family relationships for purposes, such as:
   - proving legal dependency
   - obtaining inheritance benefits
   - receiving insurance payments
   - conducting genealogy research

4. Providing public health information for purposes, such as:
   - evaluating prenatal care
   - immunizing children
   - caring for children with congenital anomalies or abnormal conditions
   - evaluating the needs for health facilities
   - planning and evaluating the effectiveness of family planning programs
   - monitoring risk factors that cause poor pregnancy outcomes

AFFIDAVIT OF BIRTH PARENT TO THE BIRTH

STATE OF CONNECTICUT

TOWN OF _____

I, _____, under penalty of perjury, hereby depose and say:
(Full name of Birth Parent)

1. I am over 18 years of age and understand the obligations of an oath.

2. I am a resident of _____.
(Town and state)

3. On _____ at _____ I gave birth to my son/daughter (circle one),
(date) (time-denote am or pm)

_____ at _____,
(Full name of child) (number and street address of birthplace)

_____,
(Town) (State) (Zip code)

_____
(Printed name of Birth Parent)

_____
(Residence no. and street)

_____
(town) (state) (zip code)

_____
(Signature of Birth Parent)

Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Date Commission Expires:_____

AFFIDAVIT OF NON-BIRTH PARENT TO THE BIRTH

STATE OF CONNECTICUT

TOWN OF _____

I, _____, under penalty of perjury, hereby depose and say:
(Full name of Non-Birth Parent)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of _____.
(Town and state)

3. On _____ at _____, I witnessed _____
(date) (time- denote am or pm) (Full name of Birth Parent)

give birth to our son/daughter (circle one), _____
(Full name of child)

at _____; _____
(Number and street address of birthplace) (Town) (State) (Zip code)

_____
(Printed name of Non-Birth Parent)

_____
(Residence no. and street)

_____
(Town) (State) (Zip code)

_____
(Signature of Non-Birth Parent)

Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Date Commission Expires: _____

AFFIDAVIT OF WITNESS TO THE BIRTH

STATE OF CONNECTICUT

TOWN OF _____

I, _____, under penalty of perjury, hereby depose and say:
(Full name of witness)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of _____.
(Town and state)

3. My relationship to the Birth Parent is _____.
(State relationship)

4. On _____ at _____, I witnessed _____
(date) (time-denote am or pm) (full name of Birth Parent)

give birth to their son/daughter (circle one) at _____,
(Number and street address of birthplace)

_____.
(town) (state) (zip code)

_____
(Printed name of witness)

_____
(Residence no. and street)

_____
(town) (state) (zip code)

_____
(Signature of witness)

Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Date Commission Expires: _____

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AFFIDAVIT OF WITNESS TO THE BIRTH

STATE OF CONNECTICUT

TOWN OF_____

I, _____, under penalty of perjury, hereby depose and say:
(Full name of witness)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of _____.
(Town and state)

3. My relationship to the Birth Parent is _____.
(State relationship)

4. On _____ at _____, I witnessed _____
(date) (time-denote am or pm) (full name of Birth Parent)

give birth to their son/daughter (circle one) at _____,
(Number and street address of birthplace)

_____.
(town) (state) (zip code)

_____
(Printed name of witness)

_____
(Residence no. and street)

_____
(town) (state) (zip code)

_____
(Signature of witness)

Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Date Commission Expires:_____

AFFIDAVIT OF WITNESS TO THE PREGNANCY

STATE OF CONNECTICUT

TOWN OF_____

I, _____, under penalty of perjury, hereby depose and say:
(Full name of witness)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of _____.
(Town and State)

3. I have known _____ for _____ months/years (circle one).
(Full name of Birth Parent) (number)

4. My relationship to the birth parent is _____
(State relationship)

5. I met with _____ on _____ at
(Full name of Birth Parent) (date)

_____.
(place)

6. I observed that Birth Parent was pregnant at the time.

_____
(Printed name of witness)

_____
(Residence no. and street)

_____
(Town) (State) (Zip code)

_____
(Signature of witness)

Subscribed and sworn to before me
this _____ day of _____, _____.

_____
Notary Public

Date Commission Expires:_____

ERICK RUSSELL
TREASURER

State of Connecticut
Office of the Treasurer

SARAH SANDERS
DEPUTY TREASURER

Congratulations on the birth of your new baby!

With all the joy (and exhaustion!) this new arrival brings to you and your family, saving for their college education may be the last thing on your mind. That's understandable! But getting started is easy, and it's something you could even do today.

Part of my job is administering the Connecticut Higher Education Trust (CHET), the state's college savings program that invests your money so it can grow over time, making education more affordable and offering tax advantages. Opening a CHET account can give you a head start on saving for future education expenses through the CHET Baby Scholars initiative.

When you open a CHET account within the first year of your child's birth or adoption, the state will contribute the first $100 towards their future education, without any contribution from you.

In minutes, you can start building the foundation for your child's education. Visit **www.aboutchet.com/babyscholars** for all the details. By answering just a few questions, you can open your account on the site today. The earlier you start saving, the more your account can grow.

Again, my most sincere congratulations to you and your family on the arrival of your new baby!

Sincerely,

Erick Russell
Connecticut State Treasurer



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

It's Your Best Shot!
CT WiZ
Connecticut
Immunization Information System

Notice to Patients about reporting to CT WiZ

As required by law and to protect your health, your doctor will share immunization information (i.e., "shots" or "vaccines") with the State of Connecticut Department of Public Health (DPH). DPH will store your shots in its immunization system called CT WiZ. CT WiZ helps make sure you get the shots needed to protect you against vaccine preventable diseases. If your shot record is lost or not available, DPH can share it with you and your doctor. You can choose to exclude your shot information from CT WiZ by sending a signed written request to the DPH Immunization Program. Immunization systems help prevent and control disease. All information is kept confidential as required by law.

Notificación a pacientes acerca el reporte de inmunizaciones a CT WiZ

Según lo exige la ley y para proteger su salud, su médico compartirá la información de inmunizaciones ("vacunas") con el Departamento de Salud Pública (DPH) del Estado de CT. DPH almacenará sus vacunas en su sistema de inmunización llamado CT WiZ. CT WiZ ayuda a asegurar que reciba las vacunas necesarias para protegerlo contra enfermedades peligrosas. Si el registro de sus vacunas se pierde o no está disponible, DPH puede compartirlo con usted y su médico. Usted puede optar por excluir la información de sus vacunas de CT WiZ enviando una solicitud firmada por escrito al Programa de Inmunización de DPH. Los sistemas de inmunización ayudan a prevenir y controlar enfermedades. Toda la información se mantiene confidencial como lo exige la ley.

Connecticut Department of Public Health Immunization Program
Departamento de Salud Pública de Connecticut Programa de Inmunización
Phone: 860-509-7929 Fax: 860-707-1925
Visit: ct.gov/getmyvaccinerecord

SCAN ME

CONNECTICUT
Public Health

rev 5/2025

Rev. 1/2016

Social Security Numbers for Newborns

The State of Connecticut Department of Public Health and the Federal Social Security Administration are offering you this valuable service.

A NOTE FROM SSA:
The easiest time to get a Social Security Number for your child is when you give information for your child's birth certificate. If you wait to apply at a Social Security office, you will need to provide proof of your child's U.S. Citizenship, age and identity. Social Security will also need to verify your child's birth certificate which may take up to 12 weeks.

By completing this form and requesting a Social Security number for your new baby, the State of Connecticut Department of Public Health will electronically transmit your request to the Federal Social Security Administration. A Social Security card will be mailed to you within 3 weeks, eliminating the need for you to personally visit a Social Security office with evidence of your child's identity, birth date and citizenship.

Must your child have a Social Security Number? No, it is voluntary. However, your child will need a Social Security Number in order for you to claim your child on your income tax return, open a bank account for your child, buy savings bonds for your child, obtain medical coverage for your child, apply for government services for your child.

Social Security rarely uses the information you supply for any purpose other than for issuing a Social Security number and card. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g.to the Government Accountability Office and Department of Veteran's Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

Social Security may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies.

FOR INFORMATION OR ANSWERS TO YOUR SOCIAL SECURITY QUESTIONS, Please contact the Federal Social Security Administration at www.socialsecurity.gov or call toll free: 1-800-772-1213 (for deaf or hard of hearing: call the TTY line at 1-800-325-0778).

ENUMERATION AT BIRTH CONSENT FORM

Baby's Name as Reported on Birth Certificate:

_____

(A Social Security number cannot be issued for a child that has not been named)

1) Do you want a Social Security Number issued for your baby?

□ YES **□ NO**

2) Do you authorize the Social Security Administration to provide the Social Security number to the State of Connecticut to add it to the State's birth file? (The confidentiality of Connecticut birth records is protected by state statute (§CGS 7-51))

□ YES **□ NO**

Signature of Parent _____ **Date**_____

BIRTH PARENT'S MEDICAL RECORD #	**CHILD'S** MEDICAL RECORD #
	IF MULTIPLE BIRTH, this worksheet is for:

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

MEDICAL DATA WORKSHEET for the LIVE BIRTH CERTIFICATE (v2003)

Connecticut General Statute §7-48 requires the medical practitioner in attendance of a birth and the practitioner providing prenatal care to provide the medical information required by the certificate not later than 72 hours after the birth. When a birth occurs in an institution, the institution's designated representative shall obtain all available data required by the certificate, prepare the certificate, certify that the child was born alive at the place and time and on the date stated, and file the certificate not later than ten days after such birth. Each birth certificate shall contain such information as the Department of Public Health may require and shall be completed in its entirety.

Birth Parent's Name:

_____ _____ _____ _____
First Middle Last Generational ID

1b. Date of birth of this child

__ __ / __ __ / __ __ __ __
Month Day Year

1c. Time of birth of this child

__ __ : __ __ ☐ AM ☐ PM ☐ Military
hour minute

1d. Sex of this child

❑ Male ❑ Female
❑ Not yet determined/Unknown

1e. Place of Birth Type:

- ☐ Hospital
- ☐ Free Standing Birthing Center
- ☐ Clinic/Doctor's Office
- ☐ Born En-route or on Arrival
- ☐ Residence:

Was this a planned delivery at home?
☐ Yes ☐ No ☐ Unknown

1f. Birthplace Name and Address:

Facility Name: _____

Street address of birth location:

_____ _____
Street Apt #

_____ _____ _____
City/Town County State

MEDICAL CERTIFICATION

I HEREBY CERTIFY THAT THE CHILD WAS BORN AT THE HOUR, DATE, AND PLACE STATED ABOVE

Certifier's Title:

- ☐ MD
- ☐ DO
- ☐ CNM
- ☐ Other Midwife-CPM
- ☐ Birth Parent
- ☐ Non-Birth Parent
- ☐ Other – specify: _____

Certifier's Printed Name: _____
First MI Last Generational ID

Certifier's Signature:

_____ **Date Signed:** _____
First MI Last Generational ID

CT License Number: _____ **National Provider ID:** _____

Certifier's Address:

_____
Street/Apt # City/Town State ZIP code

8h. Birth Attendant's Information: The attendant at birth is the person physically present at the delivery room who is responsible for the delivery even if they do not themselves deliver the infant.

Title of Birth Attendant:

☐ MD ☐ DO ☐ CNM ☐ Other Midwife-CPM ☐ Birth Parent ☐ Non-Birth Parent

☐ Other (specify): _____

Name of Birth Attendant:

☐ SAME AS CERTIFIER

_____
First MI Last Generational ID

CT License Number: _____ **National Provider ID (NPI):** _____

PRENATAL INFORMATION

Sources: Prenatal care records, Birth Parent's medical records, labor and delivery records

Information for the following items should come from the Birth Parent's prenatal care records and from other medical reports in the Birth Parent's chart, as well as the infant's medical record. If the Birth Parent's prenatal care record is not in the hospital chart, please contact the Birth Parent's prenatal care provider to obtain the record, or a copy of the prenatal care information.

Preferred and acceptable sources are given before each section.
Please do not provide information from sources other than those listed.

WHERE INFORMATION FOR AN ITEM CANNOT BE LOCATED, PLEASE WRITE "UNKNOWN" ON THE PAPER COPY OF THE WORKSHEET.

9a. Did Birth Parent Have Prenatal Care:

□ YES □ NO □ Unknown

Is the prenatal care record available for this Birth Parent? Is it current? If the prenatal care record is not available *or* if the record is not current (i.e., from pre-registration), please contact the prenatal care provider for an updated record before completing the remaining items.

9b. Principal Source of Payment for Prenatal Care:

□ Husky or Medicaid
□ Private/Employer Insurance
□ Self-pay (No third party identified)
□ Indian Health Service
□ CHAMPUS/TRICARE
□ Other Government
□ Other – specify: _____

9c. Date of FIRST prenatal care visit:

__ __ / __ __ / __ __ __ __
Month Day Year

Prenatal care begins when a physician or other health professional first examines and/or counsels as part of an ongoing program of care for the pregnancy.

9d. Total number of prenatal care VISITS for this pregnancy:

_____

Count only those visits recorded in the record. If the prenatal records do not appear to be current, please contact the prenatal care provider for updated information.

9e. Date last normal menses began:

__ __ / __ __ / __ __ __ __
Month Day Year

Do NOT calculate the date if it is not specified in the prenatal care record. If any part of the date is available, enter the available parts (e.g., 04/99/2014). Otherwise, enter 99-99-9999.

9f. Method of Determining EDD: Method used by prenatal care provider to establish the Estimated Date of Delivery (EDD).
Check one:

□ Known LMP consistent with an ultrasound (the earliest possible >7 weeks)
□ Ultrasound (the earliest possible >7 weeks) NOT consistent with known LMP
□ Ultrasound alone, LMP date is only partially known or not known
□ LMP alone, did not have an ultrasound prior to labor and delivery
□ ART: Date of Assisted Reproductive Technology (ART) established the EDD
□ No EDD determined
□ Method unknown

Known LMP means that all parts of the LMP date (MM-DD-YYYY) were recorded in the Birth Parent's prenatal records. If only a partial LMP date is available, do not select the first two options.
ART (Assisted Reproductive Technology) includes embryo transfer, intrauterine insemination (IUI), ZIFT, GIFT.
If no prenatal care was received, then select "No EDD determined" since a prenatal provider did not date the pregnancy.
If the prenatal care record is not available or does not specify the method used to determine EDD, then select "Method unknown".

9g. Number of previous LIVE births now LIVING:

____ □ None

Do not include this child. Include all live births delivered before this infant in this pregnancy and in previous pregnancies.

9h. Number of previous LIVE births now DEAD:

____ □ None

Do not include this child. Include all live-births-now-dead delivered before this infant in this pregnancy and in previous pregnancies.

9i. Date of last live birth:

__ __ / __ __ __ __
Month Year

9j. Total number of other pregnancy outcomes that did not result in a live birth:

_____ ☐ None

Include pregnancy losses of any gestational age--spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in this pregnancy and in previous pregnancies.

9k. Date of last other pregnancy outcome:

__ __ / __ __ __ __
Month Year

Date when last pregnancy that did not result in a live birth ended.

9l. Did Birth Parent's blood test positive for syphilis during this pregnancy? If yes, provide test date(s).

1st test:

☐ YES, positive test result on __ __ /__ __ /__ __ __ __
Month Day Year

☐ No

☐ Unknown

2nd test:

☐ YES, positive test result on __ __ /__ __ /__ __ __ __
Month Day Year

☐ No

☐ Unknown

9m. Was Birth Parent's prenatal care record available for completing worksheet?

☐ YES ☐ NO ☐ Unknown

10a. Birth Parent's risk factors for this pregnancy: Check all that apply.

Diabetes: Glucose intolerance requiring treatment. If diabetes is present, check either pre-pregnancy or gestational. Do not check both.

- ☐ **Pre-pregnancy:** Diagnosis prior to this pregnancy
- ☐ **Gestational:** Diagnosis in this pregnancy

Hypertension: Elevation of blood pressure above normal for age, gender, and physiological condition. If hypertension is present, check either pre-pregnancy or gestational. Do not check both.

- ☐ **Pre-pregnancy** (Chronic): Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
- ☐ **Gestational** (PIH, preeclampsia): Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).
- ☐ **Eclampsia:** Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.

☐ **Previous preterm birth:** History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.

☐ **Pregnancy resulted from infertility treatment** - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).

If Yes, check all that apply:

- ☐ **Fertility-enhancing drugs, artificial insemination or intrauterine insemination:** Any fertility- enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
- ☐ **Assisted reproductive technology:** Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.

☐ **Birth Parent had a previous cesarean delivery:** Previous operative delivery by extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

If Yes, how many previous cesareans? ____

☐ **Birth Parent used tobacco cigarettes during this pregnancy:** Prenatal care record indicates that Birth Parent used tobacco cigarettes during pregnancy. Include any reported use during this pregnancy, even if Birth Parent reported cessation upon learning of the pregnancy. Do not include e-cigarettes or vaping cigarettes.

☐ **Birth Parent used alcohol during this pregnancy:** Prenatal care record indicates that Birth Parent used alcohol during pregnancy. Include any reported use during this pregnancy, even if Birth Parent reported cessation upon learning of the pregnancy.

☐ **None of the above**

☐ **Unknown**

10b. Infections present and/or treated during this pregnancy:
Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

Check all that apply.

- ☐ **Chlamydia:** a diagnosis of or positive test for Chlamydia trachomatis
- ☐ **Gonorrhea:** a diagnosis of or positive test for Neisseria gonorrhoeae
- ☐ **Syphilis:** also called lues - a diagnosis of or positive test for Treponema pallidum
- ☐ **Hepatitis B:** HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus
- ☐ **Hepatitis C:** non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus
- ☐ **HIV+:** a diagnosis of or positive test for human immunodeficiency virus
- ☐ **None of the above**

10c. Obstetric procedure: Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.

- ☐ **External cephalic version:** Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.
  - ☐ **Successful** ☐ **Failed**
- ☐ **None of the above**

LABOR AND DELIVERY

Sources: Labor and delivery records, Birth Parent's medical records

11a. Principal Source of Payment for Delivery:

- ☐ Husky or Medicaid
- ☐ Private/Employer Insurance
- ☐ Self-pay (No third party identified)
- ☐ Indian Health Service
- ☐ CHAMPUS/TRICARE
- ☐ Other Government
- ☐ Other – specify: _____

11b,c. Was the Birth Parent transferred to this facility for maternal medical or fetal indications for delivery?

- ☐ Yes, from: _____
  Name of facility Birth Parent transferred from
- ☐ No
- ☐ Unknown

Transfers include hospital to hospital, birth facility to hospital, etc.

11d. Birth Parent's weight at delivery: _____ (in pounds)

11e. Characteristics of labor and delivery: Check all that apply.

- ☐ **Induction of labor:** Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.
- ☐ **Augmentation of labor:** Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.
- ☐ **Steroids (glucocorticoids) for fetal lung maturation received by the Birth Parent prior to delivery:** Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the Birth Parent as an anti-inflammatory treatment.
- ☐ **Antibiotics received by the Birth Parent during labor:** Includes antibacterial medications given systemically (intravenous or intramuscular) to the Birth Parent in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.
- ☐ **Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F):** Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38°C (100.4°F).
- ☐ **Epidural or spinal anesthesia during labor:** Administration to the Birth Parent of a regional anesthetic for control of the paln of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.
- ☐ **None of the above**

11f. Method of Delivery:

Fetal presentation at birth: Check one.

- ☐ **Cephalic:** Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- ☐ **Breech:** Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech
- ☐ **Other:** Any other presentation not listed above

Final route and method of delivery: Check one.

- ☐ **Vaginal/Spontaneous:** Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.
- ☐ **Vaginal/Forceps:** Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.
- ☐ **Vaginal/Vacuum:** Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.
- ☐ **Cesarean:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.

  If cesarean, was a trial of labor attempted? Labor was allowed, augmented or induced with plans for a vaginal delivery.

  ☐ Yes ☐ No

11g. Maternal morbidity: Serious complications experienced by the Birth Parent associated with labor and delivery.

Check all that apply.

- ☐ **Maternal transfusion:** Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- ☐ **Third- or fourth-degree perineal laceration:** 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.
- ☐ **Ruptured uterus:** Tearing of the uterine wall.
- ☐ **Unplanned hysterectomy:** Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.
- ☐ **Admission to intensive care unit:** Any admission of the Birth Parent to a facility/unit designated as providing intensive care.
- ☐ **None of the above**

NEWBORN

Sources: Labor and delivery records, Newborn's medical records, Birth Parent's medical records

12a. Plurality of this birth:

- ❑ Singleton
- ❑ Twins
- ❑ Triplets
- ❑ Quadruplets
- ❑ Other: _____

Include all infants delivered (alive or dead) in this pregnancy when determining plurality.

12c. Total LIVE births in this pregnancy: _____

If not single birth, specify number of infants in this pregnancy born alive.

12b. Birth Order of this infant:

- ❑ 1st born
- ❑ 2nd born
- ❑ 3rd born
- ❑ 4th born
- ❑ Other: _____

If a multiple birth, circle the birth order of this child named above. Include all infants delivered (alive or dead) in this pregnancy when determining birth order.

12d. Birthweight:

Choose one.

GRAMS: _____

or

LBS/OZS: ____ /____

12e. Apgar score:

Score at 5 minutes: _____

If 5 minute score is less than 6:

Score at 10 minutes: _____

12f. Obstetric estimate of gestation at delivery:

Completed weeks: _____

The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. **Do not compute based on date of the last menstrual period and the date of birth.**

12g. Abnormal conditions of the newborn: Disorders or significant morbidity experienced by the newborn.

Check all that apply.

□ **Assisted ventilation required immediately following delivery:** Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.

□ **Assisted ventilation required for more than six hours:** Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).

□ **NICU admission:** Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.

□ **Newborn given surfactant replacement therapy:** Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.

□ **Antibiotics received by the newborn for suspected neonatal sepsis:** Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine etc.) given systemically (intravenous or intramuscular).

□ **Seizure or serious neurologic dysfunction:** Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.

□ **Neonatal Abstinence Syndrome:** Infant diagnosed with Neonatal Abstinence Syndrome based on the results of the hospital's standard screening policy for maternal drugs of abuse and newborn NAS screening.

□ **None of the above**

13a. Congenital anomalies of the newborn:
Malformations of the newborn diagnosed prenatally or after delivery.

Check all that apply.

□ **Anencephaly:** Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).

□ **Meningomyelocele/Spina bifida:** Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).

□ **Cyanotic congenital heart disease:** Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.

□ **Congenital diaphragmatic hernia:** Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.

□ **Omphalocele:** A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.

□ **Gastroschisis:** An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.

□ **Limb reduction defect (excluding congenital amputation and dwarfing syndromes):** Complete or partial absence of a portion of an extremity associated with failure to develop.

□ **Cleft Lip with or without Cleft Palate:** Incomplete closure of the lip. May be unilateral, bilateral or median.

□ **Cleft Palate alone:** Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft lip with or without Cleft Palate category above.

□ **Down Syndrome - (Trisomy 21)**

□ **Karyotype confirmed** □ **Karyotype pending**

□ **Suspected chromosomal disorder:** Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.

□ **Karyotype confirmed** □ **Karyotype pending**

□ **Hypospadias:** Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.

□ **None of the above**

13b. Immunization Information:

Did newborn receive Hepatitis B vaccine: □ Yes, Date of vaccine: ___/___/_____ Lot no._____
□ No
□ Unknown

Did newborn receive HBIG vaccine: □ Yes, Date of vaccine: ___/___/_____
Time of vaccine: _____:_____ am / pm / military
□ No
□ Unknown

13c. Was infant transferred within 24 hours of delivery?

Check "yes" if the infant was transferred from this facility to another facility within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.

□ Yes, to: _____
Name of facility infant transferred to
□ No
□ Unknown

13d. Is infant living at time of report?

□ Yes □ No □ Infant transferred, status unknown

Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.

13e. Is infant being breastfed at discharge?

□ Yes □ No □ Unknown

If the infant was receiving breastmilk/colostrum during the period between birth and discharge from the hospital. Include attempts to establish breastmilk production prior to discharge by breastfeeding or pumping (expressing) milk.

14a. Medical Informant:

Name and date of person completing this Facility Worksheet:

_____ _____ _____ _____ _____
First **Middle** **Last** **Gen. ID** **Title**

Signature_____ **Date Completed**_____

14b. COMMENTS:

BIRTH PARENT'S MEDICAL RECORD #	**CHILD'S** MEDICAL RECORD #
BIRTH PARENT'S NAME:	

REV 01/2022

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

BIRTH PARENT'S WORKSHEET FOR CHILD BIRTH CERTIFICATE (v2003)

The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship, and parentage. This document will be used by your child throughout life. State laws provide protection against the unauthorized release of identifying information from the birth certificates to ensure the confidentiality of the parents and their child.

It is very important that you provide complete and accurate information to all the questions. In addition to information used for legal purposes, other information from the birth certificate is used by health and medical researchers to study and improve the health of Birth Parents and newborn infants. Items such as parent's education, race, and smoking will be used for studies but will not appear on copies of the birth certificate issued to you or your child.

FOR HOSPITAL BIRTHS: DO NOT TAKE THIS FORM HOME. SUBMIT COMPLETED FORM TO THE HOSPITAL BIRTH REGISTRAR PRIOR TO DISCHARGE

FOR HOME BIRTHS: SUBMIT COMPLETED FORM TO REGISTRAR OF VITAL RECORDS IN THE TOWN OF BIRTH

CHILD'S INFORMATION

1a. Child's Legal Name: Print your child's name **EXACTLY** as you want it to appear on the birth certificate. To change it in the future will require a court ordered legal name change.

First _____ Middle _____ Last _____ Generational ID _____

❑ **Child's name not yet chosen**

Date of birth of this child

__ __ / __ __ / __ __ __ __
Month Day Year

Plurality of this birth
Include all infants delivered (alive or dead) in this pregnancy when determining plurality and birth order.

- ❑ Singleton
- ❑ Twins
- ❑ Triplets
- ❑ Quadruplets
- ❑ Other _____

Birth Order of this child
If a multiple birth, circle the birth order of the child named above.

- ❑ 1st born
- ❑ 2nd born
- ❑ 3rd born
- ❑ 4th born
- ❑ Other _____

INFORMATION ON BIRTH PARENT

2a. Birth Parent's current legal name

First _____ Middle _____ Last _____ Generational ID _____

2b. Birth Parent's name prior to first marriage (Maiden name; Last name given at birth or on Birth Certificate)

□ SAME AS CURRENT LEGAL NAME

First _____ Middle _____ Last _____ Generational ID _____

2c. Birth Parent's date of birth	2d. Birth Parent's Place of Birth
__ __ / __ __ / __ __ __ __ Month Day Year	U.S. State _____ U.S. territory _____ (i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, or Northern Marianas) Foreign country _____ If CANADA, provide province _____

2e. Although your marital status does not print on your child's birth certificate, it is necessary to register the record legally and properly. Failure to provide accurate marital status information can cause legal difficulties throughout your child's life.

Were you married at the time you conceived this child, at the time of birth, or at any time between conception and giving birth?

- ❑ **Yes**
- ❑ **No** *If no, has an Acknowledgement of Parentage been completed? (That is, have you and the Non-Birth Parent signed a State of Connecticut Acknowledgment of Parentage form in which the Non-Birth Parent accepted legal responsibility for the child?)*
  - ❑ **Yes,** *an Acknowledgement of Parentage* has been completed.
  - ❑ **No,** *an Acknowledgement of Parentage* has not been completed. (*Information about the Non-Birth Parent cannot be included on the birth certificate. Information about the procedures for adding the Non-Birth Parent's information to the Birth Certificate after it has been filed can be obtained from the State Vital Records Office.)*

2f. Birth Parent's Residence:

Provide the actual street location and the official name of the town/city where your permanent residence is located. For example, the location for paying taxes, voting, etc., but not necessarily used for mailing address.

_____ _____ _____
House Number Street (Do not enter PO Boxes or Rural Route numbers) Apt / Unit

_____ _____ _____
City/Town State ZIP code

County: _____ If not United States, *country* _____

Is the residence inside city limits? (Non-CT residents only) ❑ Yes ❑ No ❑ Don't know

How long has the Birth Parent lived at the current residence reported above? _____ Years _____ Months

2g. Address where mail is received: ❑ Same as residence address above

_____ _____ _____
House Number Street, Rural Route, P.O. Box Apt / Unit

_____ _____ _____
City/Town State ZIP code

County: _____ If not United States, *country* _____

3a. Birth Parent's Spoken Language (check all that apply):

- ❑ American sign language (ASL)
- ❑ Armenian
- ❑ Chinese, Cantonese
- ❑ Chinese, Mandarin
- ❑ English
- ❑ French (including Cajun, Patois)
- ❑ French Creole (for example, Haitian)
- ❑ Gujarathi
- ❑ Khmer
- ❑ Korean
- ❑ Laotian
- ❑ Persian
- ❑ Polish
- ❑ Portuguese
- ❑ Russian
- ❑ Serbo-Croatian
- ❑ Spanish
- ❑ Vietnamese
- ❑ Other Language –specify: _____

Race and Hispanic Ethnicity: Race and ethnicity are self-identification data items in which respondents choose the race or races with which they most closely identify and indicate whether or not they are of **Hispanic, Latino/a, or Spanish** origin. Race and ethnicity are considered separate and distinct identities.

Please complete both items.

Definition of Hispanic, Latino/a, or Spanish Origin: Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be any race.

- "**Hispanic, Latino/a, or Spanish origin**" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin – *regardless of race*.

3b. Is the Birth Parent Spanish/Hispanic/Latina?

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina: _____

(e.g., Spaniard, Salvadoran, Dominican, Columbian)

Definition of Race Categories:
A person may indicate self-identification with two or more races by selecting multiple race categories.

- "**White**" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race(s) as "White" or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
- "**Black or African American**" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race(s) as "Black, African American, or Negro"; or report entries such as African American, Kenyan, Nigerian, or Haitian.
- "**American Indian and Alaska Native**" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- "**Asian**" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "**Native Hawaiian and Other Pacific Islander**" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

3c. Birth Parent's Race: Please check one or more races to indicate what they consider themself to be.

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native: _____

(Name of enrolled or principal tribe)

Asian
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian: _____

(e.g., Thai, Cambodian, Malaysian)

Pacific Islander
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander: _____

- ❑ Other Race: _____

4a. Birth Parent's Social Security Number:

Furnishing parent Social Security Numbers (SSNs) is required by Federal Law, 42 USC 405(c) (section 205(c) of the Social Security Act). The numbers will be made available to the Connecticut Department of Social Services to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

			-			-				

☐ **I DO NOT HAVE A SOCIAL SECURITY NUMBER**

4b. Birth Parent's occupation:
(Ex. Nurse's aide, machine operator, car salesman, student, homemaker)

4c. Birth Parent's type of business/industry:
(Ex. Nursing home, toy manufacturer, auto dealership, high school, own home)

4d. Highest level of schooling the Birth Parent has completed at time of delivery:

Check the box that best describes their education. If currently enrolled, check the box that indicates the previous grade or highest degree received.

- ❑ 8th grade or less
- ❑ 9th-12th grade, no diploma
- ❑ High school graduate or GED completed
- ❑ Some college credit, but no degree
- ❑ Associate degree (e.g., AA, AS, Technical school)
- ❑ Bachelor's degree (e.g., BA, AB, BS)
- ❑ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ❑ Doctorate or Professional degree (e.g., PhD, EdD, MD, LLB)

4e. Did the Birth Parent receive WIC (Women's, Infant & Children) food because of this pregnancy?

- ☐ Yes
- ☐ No

4f. Did the Birth Parent smoke just before or during this pregnancy? (Do not include e-cigarettes or vaping cigarettes)

❑ Yes, I smoked during the three months before I became pregnant and/or while I was pregnant.

For the three months before pregnancy, on an average day I smoked: _____cigs or _____ packs.
During the first 3 months of pregnancy, on an average day I smoked: _____cigs or _____ packs.
During the second 3 months of pregnancy, on an average day I smoked: _____cigs or _____ packs.
During the last 3 months of pregnancy, on an average day I smoked: _____cigs or _____ packs.

❑ No, I did not smoke during the three months before I became pregnant or while I was pregnant.

4g. Did the Birth Parent use alcohol regularly during this pregnancy? If so, how many drinks did they consume in *an average week*?

❑ No, I did not drink regularly during this pregnancy.

❑ Yes, I drank _____ drinks in ***an average week*** during this pregnancy.

4h. Birth Parent's height:

_____feet _____ inches

4i. Birth Parent's weight immediately before they became pregnant with this child:

Pre-pregnancy weight was _____ pounds

INFORMATION ON NON-BIRTH PARENT

Fill in the Non-Birth Parent's information ONLY if the parents are legally married to each other or if both parents have signed the VS-56 "ACKNOWLEDGEMENT OF PARENTAGE" form.

5a. Non-Birth Parent's current legal name:

First _____ Middle _____ Last _____ Generational ID _____

5b. Non-Birth Parent's name prior to first marriage (Last name given at birth or on Birth Certificate)

☐ SAME AS CURRENT LEGAL NAME

First _____ Middle _____ Last _____ Generational ID _____

5c. Non-Birth Parent's date of birth:

__ __ / __ __ / __ __ __ __
Month Day Year

5d. Non-Birth Parent's Place of Birth:

U.S. State _____

U.S. territory _____
(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, or Northern Marianas)

Foreign country _____

If CANADA, provide province _____

6a. Non-Birth Parent's spoken language:

- ❑ American sign language (ASL)
- ❑ Armenian
- ❑ Chinese, Cantonese
- ❑ Chinese, Mandarin
- ❑ English
- ❑ French (including Cajun, Patois)
- ❑ French Creole (for example, Haitian)
- ❑ Gujarathi
- ❑ Khmer
- ❑ Korean
- ❑ Laotian
- ❑ Persian
- ❑ Polish
- ❑ Portuguese
- ❑ Russian
- ❑ Serbo-Croatian
- ❑ Spanish
- ❑ Vietnamese
- ❑ Other Language –specify: _____

Race and Hispanic Ethnicity: Race and ethnicity are self-identification data items in which respondents choose the race or races with which they most closely identify and indicate whether or not they are of **Hispanic, Latino/a, or Spanish** origin. Race and ethnicity are considered separate and distinct identities.

Please complete both items.

Definition of Hispanic, Latino/a, or Spanish Origin: Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be any race.

- **"Hispanic, Latino/a, or Spanish origin"** refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin – *regardless of race*.

6b. Is the Non-Birth Parent Spanish/Hispanic/Latino?

- ❑ No, not Spanish/Hispanic/Latino
- ❑ Yes, Mexican, Mexican American, Chicano
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina: _____
  (e.g., Spaniard, Salvadoran, Dominican, Columbian)

Definition of Race Categories:

- "**White**" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race(s) as "White" or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
- "**Black or African American**" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race(s) as "Black, African American, or Negro"; or report entries such as African American, Kenyan, Nigerian, or Haitian.
- "**American Indian and Alaska Native**" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- "**Asian**" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "**Native Hawaiian and Other Pacific Islander**" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

6c. Non-Birth Parent's Race: Please check one or more races to indicate what they consider themself to be.

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native:

_____
(Name of enrolled or principal tribe)

Asian

- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian: _____
(e.g., Thai, Cambodian, Malaysian)

Pacific Islander

- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander:

_____

- ❑ Other Race:

_____

7a. Non-Birth Parent's Social Security Number:
Furnishing parent Social Security Numbers (SSNs) is required by Federal Law, 42 USC 405(c) (section 205(c) of the Social Security Act). The numbers will be made available to the Connecticut Department of Social Services to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

			-			-				

□ **I DO NOT HAVE A SOCIAL SECURITY NUMBER**

7b. Non-Birth Parent's occupation:
(Ex. Nurse's aide, machine operator, car salesman, student, homemaker)

7c. Non-Birth Parent's type of business/industry:
(Ex. Nursing home, toy manufacturer, auto dealership, high school, own home)

7d. Highest level of schooling the Non-Birth Parent has completed at time of delivery: Check the box that best describes their education. If currently enrolled, check the box that indicates the previous grade or highest degree received.

- ❑ 8th grade or less
- ❑ 9th-12th grade, no diploma
- ❑ High school graduate or GED completed
- ❑ Some college credit, but no degree
- ❑ Associate degree (e.g., AA, AS, Technical school)
- ❑ Bachelor's degree (e.g., BA, AB, BS)
- ❑ Master's degree (e.g., MA, MS, Meng, Med, MSW, MBA)
- ❑ Doctorate or Professional degree (e.g., PhD, EdD, MD, LLB)

IMMUNIZATION INFORMATION

All children born in CT are enrolled in the confidential, statewide Immunization Information System called CT WiZ (formerly CIRTS) which maintains your child's vaccination record. If you do not want your child enrolled, you must send a signed written request to opt out of CT WiZ. Include your child's full name and date of birth and mail it to CT Department of Public Health, 410 Capitol Avenue MS 11MUN, Hartford, CT 06134, or fax it to 860-707-1925. By opting out, your child's vaccination record will no longer be available in CT WiZ for you or your baby's doctor.

Please complete the information below.

8a. Pediatrician Information:

Name of baby's doctor: _____ _____ _____ _____
First Middle Last Generational ID

Name of doctor's practice: _____

Town of doctor/clinic: _____

EMERGENCY CONTACT

8b. Emergency Contact Name: _____ _____
First Last

Contact's Telephone #: _____

8c. Birth Parent's Telephone #: _____

Birth Parents Alternate Telephone #: _____

INFORMANT INFORMATION

8d. Informant's Information:

Relationship to this child: ❑ Birth Parent ❑ Non-Birth Parent ❑ Other Relative

❑ Hospital Employee ❑ Other – specify _____

Full name of person providing information in this form:

_____ _____ _____ _____
First Middle Last Generational ID

Signature of Informant: _____ **Date:** _____

FOR HOSPITAL BIRTHS: DO NOT TAKE THIS FORM HOME. **SUBMIT COMPLETED FORM TO THE HOSPITAL BIRTH REGISTRAR PRIOR TO DISCHARGE**

FOR HOME BIRTHS: SUBMIT COMPLETED FORM TO REGISTRAR OF VITAL RECORDS IN THE TOWN OF BIRTH