CERTIFICATE OF LIVE BIRTH
FLORIDA

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

Local File No. **109-**

CHILD

1. CHILD'S NAME *(First, Middle, Last, Suffix)* | 2. SEX | 3. DATE OF BIRTH *(Month, Day, Year)*

TYPE IN BLACK INK

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, Yea* | 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, Yea*

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, ≥ 12 hrs.)* ___ Precipitous Labor *(< 3 hrs.)* ___ Prolonged Labor *(≥ 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 > 38^0C (100.4^0F)
___ 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 *(≥ 30 min.)* ___ Assisted ventilation required *(≥ 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

DH 511, 04/2016, Rule 64V-1.006, Florida Administrative Code (Obsoletes Previous Editions) The Department of Health is required and authorized to collect Social Security Numbers for the reporting and registration of birth and death records as provided in section 382.0135, Florida Statutes.