



THE COUNTY OF CHAMBERS

Required Documentation for Home Birth Registration

1. **Parents' Identification**

The identifying document, with photograph, shall be presented in the following order of preference: [\[25 Texas Administration Code §181.26 \(h\)\]](#)

- (1) a passport or certificate of naturalization;
- (2) a military service or military dependent identification card;
- (3) a United States government identification card, or national identification card issued by another country;
- (4) a current driver's license or other state identification card;
- (5) an alien registration receipt card; or
- (6) an employee or student identification card, with photograph.

2. **Parent's Worksheet for Child's Birth Certificate**

Worksheet is included with this letter

3. **Medical Data Worksheet for Child's Birth Certificate** ([VS109.2](#))

This form is provided by the hospital.

A sample form has been included for your convenience.

4. **ImmTrac2 Immunization Registry Newborn Registration Form** ([FII-11936](#))

Registration form is included with this letter.

5. **Proof of pregnancy:**

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

6. **Proof that there was an infant born alive:**

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

7. **Proof that the birth occurred in the registration district:**

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

8. **Proof that the infant's birth occurred on the date stated:**

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

Please contact the Chambers County, TX local registrar's office for questions regarding home birth registration (409)267-2418, hhawthorne@chamberstx.gov.

Parent's Worksheet for Child's Birth Certificate

The information you provide on this worksheet is used to create your child's birth certificate. The birth certificate is a legal document used to prove your child's age, citizenship and parentage. Your child will use the birth certificate throughout his/her life. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Please **PRINT** your responses carefully and accurately as errors are difficult and expensive to correct.

Child's Place of Birth				
Name of Hospital or Location		Address		State
County where you live?		City		Zip
Child's Information				
Time of Birth (am / pm)	Date of Birth	Plurality (circle one)		Sex: (female/male)
		Single / Twin / Triplets / Quadruplets / Quintuplets / Sextuplets / Eight / Nine / Ten		
Birth Order (circle one)				
First / Second / Third / Fourth / Fifth / Sixth / Seventh / Eighth / Ninth / Tenth / Conjoined				
Mother's Current Legal Name				
First Name:	Middle Name:	Last Name:		Suffix:
Child's Current Legal Name				
First Name:	Middle Name	Last Name:		Suffix:
Mother's Residence Address				
Residence Address		Apt #	State	County Zip
City/Town		Inside City Limits?	Mailing address same as residence?	
Mother's Mailing Address (leave blank if the same as residence)				
Mailing Address		Apt #	City/Town	State Zip
Mother's Information				
Date of Birth	Place of Birth (State/Foreign Country /Territory)	Social Security #	Apply for Baby's Social Security?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the mother wish to give up rights to the child?		Date Rights Given Up?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Education		Occupation	Type of Business	
<input type="checkbox"/> 8th Grade or Less <input type="checkbox"/> 9th – 12th Grade – No Diploma <input type="checkbox"/> High School Graduate or GED <input type="checkbox"/> Some College Credit, but not a degree <input type="checkbox"/> Associate Degree (AA, AS) <input type="checkbox"/> Bachelor's Degree (BA, AB, BS) <input type="checkbox"/> Master's Degree (MA, MS, MENG, MED, MSW, MBA) <input type="checkbox"/> Doctorate (PhD, EDD), Professional (MD, DDS, DVM, LLB, JD) <input type="checkbox"/> Unknown		Is Mother of Hispanic Origin? <i>Check only one:</i> <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Other: <input type="checkbox"/> Unknown	Mother's Race: <i>Check one or more:</i> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native* <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian* <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander* <input type="checkbox"/> Other* <input type="checkbox"/> Unknown * Specify:	

Mother's Health Information				
Did the mother receive WIC for this birth?	Height (Feet: Inches)	Mother's Weight Before Pregnancy	Cigarette Smoking Before and During Pregnancy (put "0" if you did not smoke. Otherwise indicate # cigarettes or packs per day)	
<input type="checkbox"/> Yes			3 months prior:	2nd Trimester:
<input type="checkbox"/> No			1st trimester:	3rd Trimester:
Mother's Information				
<ul style="list-style-type: none"> If you are married, your husband may be listed as the father on the birth certificate, or the information may be left blank. If you are not married, the father's name may be listed on the birth certificate only if both parents complete an Acknowledgment of Paternity. If you are or have been married to someone other than the biological father of this child, or have been married to someone other than the biological father within 300 days before this child's birth, the Acknowledgment of Paternity must also include a Denial of Paternity from your husband or former husband to allow the biological father's information to be listed on the birth certificate. 				
Marital Status		Do you wish to complete an Acknowledge of Paternity?		
<input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Currently Married <input type="checkbox"/> Married but refusing husband information		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Have you ever been married to anyone else within 300 days before the birth of your child?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Name Prior to Her First Marriage				
First Name	Middle Name	Last Name	Suffix	
Father's Current Legal Name (Biological Father)				
First Name	Middle Name	Last Name	Suffix	
Father's Information				
Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security Number		
Has Paternity Testing been done? (Genetic Testing)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Education		Occupation		Type of Business
<input type="checkbox"/> 8th Grade or Less <input type="checkbox"/> 9th – 12th Grade – No Diploma <input type="checkbox"/> High School Graduate or GED <input type="checkbox"/> Some College Credit, but not a degree <input type="checkbox"/> Associate Degree (AA, AS) <input type="checkbox"/> Bachelor's Degree (BA, AB, BS) <input type="checkbox"/> Master's Degree (MA, MS, MENG, MED, MSW, MBA) <input type="checkbox"/> Doctorate (PhD, EDD), Professional (MD, DDS, DVM, LLB, JD) <input type="checkbox"/> Unknown		<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Other: <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native* <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean
		Is Father of Hispanic Origin? <i>Check only one:</i>		Father's Race: <i>Check one or more:</i>
		<input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian* <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander* <input type="checkbox"/> Other* <input type="checkbox"/> Unknown * Specify:		
Father's Mailing Address				
Mailing Address	Apt #	City/Town	State	Zip
Mother's Medicaid Information (Complete only if applicable so your baby will be added to Medicaid)				
Mother's Name as Listed with Medicaid			Mother's Medicaid Number	
IMMTRAC Registry				
Do you consent for your baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				

Birth Worksheet for Child's Birth Certificate

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

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



Birth Worksheet for Child's Birth Certificate

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

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



Birth Worksheet for Child's Birth Certificate

Mother's Miscellaneous Information

Education Level:

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

Occupation:

Kind of Business or Industry:

Email:

Mother's Residence Address Information

Withheld by Request on AOP

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Inside City Limits:

- Yes
- No
- Unknown

Mother's Mailing Address Information

Same as Residence?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Mother Demographics

Mother's Ethnicity

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

Birth Worksheet for Child's Birth Certificate

Mother's Race

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

Father

Father's Legal Name

Title Preference: Mother Father Parent

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

Same as Father's Legal Name?

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

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

Father's Miscellaneous Information

Education Level:

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

Occupation:

Kind of Business or Industry:

Father's Mailing Address Information

Withheld by Request on AOP

Same as Mother's Mailing?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Birth Worksheet for Child's Birth Certificate

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

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

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



Birth Worksheet for Child's Birth Certificate

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

Intended Mother

Intended Mother's Current Legal Name

Title Preference: Mother Father Parent

First Name:	Middle Name:	Last Name:	Suffix:
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Intended Mother's Name Prior to First Marriage

Same as Intended Mother's Legal Name? Yes No

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

Date of Birth: ___/___/___	Age:	Birthplace: (Click Checkbox to Filter Foreign Countries Only)
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SSN:

Marital Status:

- Never Married
- Married
- Married, Husband Info Refused
- Divorced
- Widowed
- Not Stated/Unknown

Intended Mother's Medicaid Information

Intended Mothers Medicaid Chip Name:	Intended Mothers Medicaid Chip Number:
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Intended Mother's Residence Address Information

Address:	Apt:	State/Country:	County:
City/Town:	Zip:	Zip Ext:	Inside City Limits:

Intended Mother's Mailing Address Information

Same as Residence?

Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:



Birth Worksheet for Child's Birth Certificate

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

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

Birth Worksheet for Child's Birth Certificate

Cigarettes Information

Did Mother Smoke Cigarettes before or during Pregnancy? Yes No

Did Mother Report in Packs?

Did Mother Report in Cigarettes?

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

Mother's Health Information

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

HIV Testing

HIV Test Done Prenatally? Yes No Unknown

Check All that Apply:

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

HIV Test Done at Delivery? Yes No Unknown

Infant Tested for HIV at Birth? Yes No Unknown

Birth Worksheet for Child's Birth Certificate

Mother Medical – 2

Pregnancy History

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

Number of Previous Live Births Now Dead:

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

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

Prenatal

Did Mother Receive Prenatal Care? Yes No Unknown

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

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

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

Source of Prenatal Care Visits

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

Method of Delivery

Was Delivery with Forceps Attempted but Unsuccessful? Yes No

Was Delivery with Vacuum Extraction Attempted but Unsuccessful? Yes No

Fetal Presentation at Birth?

- Cephalic
- Breech
- Other

Final Route & Method of Delivery?

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

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

Mother Medical - 3

Exposure/Infections Present/Treated During Pregnancy

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

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

Risk Factor in this Pregnancy

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

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

Birth Worksheet for Child's Birth Certificate

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

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 1

General

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

Child's Weight Information

Grams:	Pounds:	Ounces:
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ImmTrac Consent

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

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

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

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 2

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

Certification

Attendant Information

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



Birth Worksheet for Child's Birth Certificate

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



Texas Immunization Registry (ImmTrac2) Newborn Registration Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name Child's Middle Name Child's Last Name

Child's Date of Birth (mm/dd/yyyy) Child's Gender: Male Female Telephone Email address

Address Apartment # / Building #

City State Zip Code County

Mother's First Name Mother's Maiden Name

Race (select all that apply) Ethnicity (select only one)
American Indian or Alaska Native Asian Black or African-American Hispanic or Latino
Native Hawaiian or Other Pacific Islander White Other Race Not Hispanic or Latino
Recipient Refused Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities
I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.
I am an IMMEDIATE FAMILY MEMBER of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.
Parent, legal guardian, or managing conservator:
Printed Name: Signature: Date:

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

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to the Texas Immunization Registry. Retain this form in your client's record.



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Registro de Inmunización de Texas (ImmTrac2)

Formulario de registro de recién nacidos

Uno de los padres, el tutor legal o el titular de la custodia debe firmar este formulario si el cliente es menor de 18 años.

Primer nombre del menor _____ Segundo nombre del menor _____ Apellido del menor _____

Fecha de nacimiento del menor (mm/dd/aaaa) _____ Género del menor: Masculino Femenino Teléfono _____ Correo electrónico _____

Dirección _____ Núm. de apartamento o edificio _____

Ciudad _____ Estado _____ Código Postal _____ Condado _____

Nombre de la Madre _____ Apellido de soltera de la madre _____

Raza (seleccione todos los que correspondan):			Grupo étnico (seleccione solo una):	
<input type="checkbox"/> Indio americano o nativo de Alaska	<input type="checkbox"/> Asiático	<input type="checkbox"/> Negro o afroamericano	<input type="checkbox"/> Hispánico o latino	
<input type="checkbox"/> Nativo de Hawái o de otra isla del Pacífico	<input type="checkbox"/> Blanco	<input type="checkbox"/> Otro	<input type="checkbox"/> No hispano o latino	
<input type="checkbox"/> Se negó a contestar			<input type="checkbox"/> Otro	

El Registro de Inmunización de Texas (ImmTrac2), es un servicio gratuito del Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida y guarda los registros de vacunación de su hijo (hasta los 18 años de edad). Con su debida autorización, la información de las vacunas que recibe su hijo se incluirá en el Registro de Inmunización de Texas. Médicos, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso a esta información para verificar que no falten vacunas importantes. Para más información consulte la sección 161.007 (d) del Código de Salud y Seguridad de Texas en statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consentimiento para incluir en el registro a un menor y para divulgar sus datos a las entidades autorizadas
Entiendo que, al dar aquí mi consentimiento, autorizo la divulgación de mis datos de vacunación al DSHS, y entiendo además que el DSHS incluirá esta información en el Registro de Inmunización de Texas. Una vez que los datos de las vacunas de mi hijo estén en el Registro de Inmunización de Texas, las siguientes entidades tendrán, por ley, acceso a ella: un distrito de salud pública o departamento de salud local, por razones de salud pública, dentro de sus zonas de jurisdicción; un médico u otro proveedor de salud legalmente autorizado para aplicar vacunas, como parte del tratamiento al menor como su paciente; una dependencia estatal que tenga la custodia legal del niño; una escuela o guardería en la que el niño esté inscrito; un pagador autorizado por el Departamento de Seguros de Texas para operar en Texas lo relacionado con la cobertura del menor. Entiendo que puedo retirar este consentimiento en cualquier momento, llenando y enviando el formulario Withdrawal of Consent al Texas Immunization Registry del Texas Department of State Health Services.

La ley estatal permite la inclusión de los registros de vacunación de los socorristas y sus familiares directos en el Registro de Inmunización de Texas. Se define como "socorrista" al empleado de la seguridad pública o voluntario cuyas funciones incluyen el responder rápidamente a una emergencia médica. Se define como "familiar directo" a los padres, cónyuges, hijos o hermanos que viven en el mismo hogar que el socorrista. Para más información, consulte la sección 161.00705 del Código de Salud y Seguridad de Texas en statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Marque la casilla de abajo para indicar si su hijo es familiar directo de un socorrista.

Soy **FAMILIAR DIRECTO** de un socorrista.

Con mi firma a continuación, DOY mi consentimiento para el registro. Deseo **INCLUIR** los datos de mi hijo en el Registro de Inmunización de Texas.

El padre o madre, tutor legal o titular de la custodia:

Nombre escrito a mano _____ Firma _____ Fecha _____

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a dshs.texas.gov/sites/default/files/hipaa/docs/DSHS-NPP-Spanish-5-1-2022.pdf para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • dshs.texas.gov/immunizations
Texas Department of State Health Services • Immunization Section • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

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HEATHER H. HAWTHORNE
COUNTY CLERK



Post Office Box 728
Anahuac, Texas 77514
409-267-2418
FAX: 406-267-8405
www.chamberscountytexas.gov

THE COUNTY OF CHAMBERS

Congratulations on the birth of your new Little Texan!

Texas Vital Statistics would like to take this opportunity to answer some commonly asked questions about birth certificates. The Department of State Health Services (DSHS) strives to improve the health, safety, and well-being of all Texans. Headquartered in Austin, we also have regional offices across the state.

General Inquiries Phone 512-776-7111 Toll-free 888-963-7111

How do I get a copy of my baby's birth certificate?

You can request and purchase a certified copy of your child's birth certificate from the local registrar's office located in the city or county where the birth occurred, or from the Texas Vital Statistics office located in Austin, Texas. Birth certificates can be ordered online, please visit www.dshs.texas.gov.

A Certified Birth Certificate is a permanent legal document filed in the State of Texas that establishes your child's identity and is used to apply for medical or government services, passports, school admission, etc.

When will I receive my baby's social security card?

If you answered "yes" to the question, "Apply for baby's social security number?" the birth information will be forwarded to the Social Security Administration as soon as the Texas Vital Statistics office receives the data from the hospital. The Social Security Administration then requires 2-3 weeks to process the information. A social security card will be mailed to parents' mailing address as provided on the worksheet for child's birth certificate. The entire process usually takes 4-6 weeks to complete. For more information, please visit the Social Security Administration website www.ssa.gov If you need to speak with someone, call us toll-free at 1-800-772-1213 or at our TTY number, 1-800-325-0778, if you're deaf or hard of hearing.

When will I receive my baby's Medicaid number?

If you provided answers to "Parent Medicaid Name" and "Parent Medicaid Number", the birth information will be forwarded to the Medicaid office as soon as the Texas Vital Statistics office receives the data. Medicaid then requires 2-3 weeks to process the information. An Infant Medicaid card will be mailed to Parent's mailing address as provided on the worksheet for child's birth certificate. The entire process usually takes 4-6 weeks to complete. Please visit the Texas Health and Human Services website <https://www.hhs.texas.gov/> for more information or call 512-424-6500/ TTY number: 512-424-6597, if you're deaf or hard of hearing.