

# Baby's Birth Certificate Application



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

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

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

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

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

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

**THE HOSPITAL DOES NOT ISSUE BIRTH CERTIFICATES**



## Congratulations on the birth of your child!

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

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

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

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

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

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

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

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

Georgia Vital Records/DPH/DHR

# STATE OF GEORGIA BIRTH WORKSHEET

1. THIS BIRTH (Single, Twin, Triplet, etc)

2. IF NOT SINGLE, SPECIFY (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, etc.)

3. NEWBORN'S NAME (FIRST MIDDLE LAST SUFFIX)

4. DATE OF BIRTH (mm/dd/yyyy)

5. TIME OF BIRTH (24 hr)

6. SEX

7. HOSPITAL FACILITY NAME AND ADDRESS (if not Hospital, give street and number)

8. CITY, TOWN OR  
LOCATION OF BIRTH

9. FACILITY ID (NPI)

 Hospital  Birthing Center  Enroute/BOA  Clinic/Doctor's Office  ER  Other (specify) \_\_\_\_\_

10. SPECIFY BIRTHPLACE

11. COUNTY, STATE AND ZIP CODE OF BIRTH

12. MOTHER'S NAME (FIRST MIDDLE LAST)

13. NAME PRIOR TO FIRST MARRIAGE (FIRST MIDDLE LAST)

14. DATE OF BIRTH (mm/dd/yyyy)

15. BIRTHPLACE (State, Territory or Foreign Country)

16. MOTHER'S SSN

17a. MOTHER'S MARITAL STATUS Married at the time of conception or time of birth?  Yes  No  UnknownIf not married, has an order of paternity or legitimation been issued by a court?  Yes  No  UnknownHave both mother and father consented in writing to have father's name on the certification or have they both signed a paternity acknowledgment?  Yes  No  Unknown17b. DATE PATERNITY ACKNOWLEDGMENT  
OR LEGITIMATION SIGNED (mm/dd/yyyy)

18. NUMBER AND STREET OF RESIDENCE

19. CITY, TOWN OR LOCATION

20. RESIDENCE STATE

Phone Number: \_\_\_\_\_ Residing at current residence for: \_\_\_\_ Years \_\_\_\_ Months

Inside city limits?  Yes  No  Unknown

21. COUNTY OF RESIDENCE

22. ZIP CODE

23. MOTHER'S MAILING ADDRESS (Street, City, State, Zip, County)  Mailing address same as above24. MOTHER'S EDUCATION LEVEL (Choose **only one** option that represents the highest level of education attained)
 Completed 1<sup>st</sup> Grade  Completed 2<sup>nd</sup> Grade  Completed 3<sup>rd</sup> Grade  Completed 4<sup>th</sup> Grade  Completed 5<sup>th</sup> Grade  Completed 6<sup>th</sup> Grade  
 Completed 7<sup>th</sup> Grade  Completed 8<sup>th</sup> Grade  Completed 9<sup>th</sup> Grade  Completed 10<sup>th</sup> Grade  Completed 11<sup>th</sup> Grade  
 Completed 12th Grade but Did NOT Graduate  High school graduate or GED
 Some college credit leading to an Associate degree but did **NOT** Graduate Some college credit leading to a Bachelor's degree but did **NOT** Graduate None Associate degree (e.g. AA, AS) Master's degree (e.g. MA, MS) Unknown Bachelor's degree (e.g. BA, BS) Doctorate (e.g. PhD, EdD, MD)

25. Primary Language spoken at Home \_\_\_\_\_

26. Mother's Occupation \_\_\_\_\_

27. Kind of business or industry \_\_\_\_\_

28. Employed during last year  Yes  No  Unknown

29. Employer's name/address: \_\_\_\_\_

Name

Street

City

State/Country

Zip Code

30. MOTHER'S ETHNICITY

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

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

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

32. FATHER'S NAME (FIRST MIDDLE LAST SUFFIX)

33. DATE OF BIRTH  
(mm/dd/yyyy)

34. BIRTHPLACE (State, Territory or Foreign Country)

35. FATHER'S SSN

36. FATHER'S RESIDENCE ADDRESS (STREET CITY STATE ZIP COUNTY)

 Address same as mother's residence address

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

- Completed 1<sup>st</sup> Grade   
  Completed 2<sup>nd</sup> Grade   
  Completed 3<sup>rd</sup> Grade   
  Completed 4<sup>th</sup> Grade   
  Completed 5<sup>th</sup> Grade   
  Completed 6<sup>th</sup> Grade  
 Completed 7<sup>th</sup> Grade   
  Completed 8<sup>th</sup> Grade   
  Completed 9<sup>th</sup> Grade   
  Completed 10<sup>th</sup> Grade   
  Completed 11<sup>th</sup> Grade   
  Completed 12<sup>th</sup> Grade but Did NOT Graduate  
 Completed 12th Grade but Did NOT Graduate   
  High school graduate or GED  
 Some college credit leading to an Associate degree but did NOT Graduate   
  Associate degree (e.g. AA, AS)   
  Bachelor's degree (e.g. BA, BS)  
 Some college credit leading to a Bachelor's degree but did NOT Graduate   
  Master's degree (e.g. MA, MS)   
  Doctorate (e.g. PhD, EdD, MD)  
 None   
  Unknown

38. Father's Occupation \_\_\_\_\_ 39. Father's Industry \_\_\_\_\_ 40. Employed during the last year?  Yes  No  Unknown

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

**42. FATHER'S ETHNICITY**

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

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

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

44. Mother's Med Record #: \_\_\_\_\_ 45a. Mother's pre-pregnancy weight: \_\_\_\_\_ lbs  Unknown 45b. Mother's weight at delivery \_\_\_\_\_ lbs  Unknown

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

48a. Did mother use alcohol during pregnancy?  Yes  No  Unknown 48b. How many drinks per week? \_\_\_\_\_

49. Did Mother smoke cigarettes before OR during this pregnancy  Yes  No  Unknown  
 # of cigarettes \_\_\_\_\_ or # of packs \_\_\_\_\_ three months before pregnancy # of cigarettes \_\_\_\_\_ or # of packs \_\_\_\_\_ first trimester  
 # of cigarettes \_\_\_\_\_ or # of packs \_\_\_\_\_ second trimester # of cigarettes \_\_\_\_\_ or # of packs \_\_\_\_\_ third trimester

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

51. Vaccinations during pregnancy (Note trimester)  TDAP Trimester \_\_\_\_\_  Flu Trimester \_\_\_\_\_  Other Trimester \_\_\_\_\_  None

**52. MOTHER PREGNANCY HISTORY**

- a. Is this the mother's first pregnancy?  Yes  No  Unknown  
 b. Number of previous live births now living \_\_\_\_\_ (Do not include this child)  
 c. Number of previous live births now dead \_\_\_\_\_  
 d. Date of last live birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)  
 e. Number of fetal deaths less than 20 weeks (including ectopic loss, induced terminations or miscarriages) \_\_\_\_\_  
 f. Number of previous fetal deaths 20 weeks or greater (including induced terminations, miscarriages or stillbirths) \_\_\_\_\_  
 g. Date of last other pregnancy outcome \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

**53. MOTHER PRENATAL CARE**

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

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

**55. METHOD OF DELIVERY**

- a. Was delivery with forceps attempted but unsuccessful?  Yes  No  Unknown
- b. Was delivery with vacuum extraction attempted but unsuccessful?  Yes  No  Unknown
- c. Fetal presentation at birth?  Cephalic  Breech  Other  Unknown
- d. Final route and method of delivery?  Vaginal/spontaneous  Vaginal/forceps  Vaginal/vacuum  Cesarean  Unknown
- e. If cesarean, was a trial labor attempted?  Yes  No  Unknown

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

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

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

- a. **DIABETES (Select one of the following)**  Pre-pregnancy (diagnosis prior to this pregnancy)  Gestational (diagnosis in this pregnancy)
- b. **HYPERTENSION (Select one of the following)**  Pre-pregnancy (chronic)  Gestational (PIH, preeclampsia)  Eclampsia
- c.  Previous preterm birth
- d. Pregnancy resulted from infertility treatment (Check all that apply):
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fertility enhancing drugs    | <input type="checkbox"/> Artificial insemination               | <input type="checkbox"/> Intrauterine insemination |
| <input type="checkbox"/> In vitro fertilization (IVF) | <input type="checkbox"/> Gamete intrafallopian transfer (GIFT) | <input type="checkbox"/> Other (specify) _____     |
- e. Other poor pregnancy outcome  Perinatal death  Small for gestational age  Intrauterine growth restriction  Other (specify) \_\_\_\_\_
- f.  Mother had a previous cesarean delivery? If selected, how many? \_\_\_\_\_
- g.  None of the above
- h.  Unknown

**58. OBSTETRIC PROCEDURES (Check all that apply)**

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

**59. ONSET OF LABOR (Check all that apply)**

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

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

- Induction of labor
- Augmentation of labor
- Non-vertex presentation
- Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery  Partial  Complete
- Antibiotics received by mother during labor
- Clinical chorioamnionitis diagnosed during labor or maternal temperature is >38 C (100.4 F)
- Moderate/heavy meconium staining of the amniotic fluid
- Fetal intolerance of labor such that one or more of the following actions was taken: in utero resuscitative measures, further fetal assessment or operative delivery
- Epidural or spinal anesthesia during labor
- None of the above
- Unknown

**61. MATERNAL MORBIDITY (Check all that apply)**

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

62. Infant's Medical Record # \_\_\_\_\_

63. OB Estimated Gestation (completed weeks) \_\_\_\_\_  Unknown64a. Apgar score (at 5 min) \_\_\_\_\_  Unknown64b. Apgar score (at 10 min) \_\_\_\_\_  Unknown65. Was infant transferred within 24 hours of delivery?  Yes  No  Unknown If yes, where? \_\_\_\_\_66. Is infant living at time of report?  Yes  No  Unknown67. Is infant being breast fed, even partially?  Yes  No  Unknown68a. Weight Unit  Grams  Pounds  Unknown68b. Weight Grams \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces \_\_\_\_\_  Unknown

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

- Assisted ventilation required immediately following delivery
- Assisted ventilation required for more than six hours
- NICU admission
- Newborn given surfactant replacement therapy
- Culture Positive Postnatal (Blood, CSF or other sources)
- Antibiotics received by newborn for suspected neonatal sepsis
- Seizure or serious neurologic dysfunction
- Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage requiring intervention)
- None of the above
- Unknown

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

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

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

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

**72. HEPATITIS VACCINATION**

- |  |   |
|--|---|
| <p>a. Did the infant receive Hepatitis B vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused</p> <p>b. If infant received Hepatitis B vaccine, number of hours after birth _____</p> <p>c. Did the infant receive Hepatitis B Immune Globulin (HBIG)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>d. If infant received HBIG, number of hours after birth _____</p> | <p>e. Hepatitis B vaccine Date _____</p> <p>f. Hepatitis B vaccine Lot Number _____</p> <p>g. HBIG Lot Number _____</p> |
|--|---|

**73. NEWBORN SCREENING**

- a. Was a metabolic screening performed for this infant?  Yes  No – Missed (transferred)  No – Parent refusal  No – Other \_\_\_\_\_  Unknown
- b. Newborn Metabolic screening number \_\_\_\_\_
- c. Was Hearing Screening performed for this infant?  Yes  Unable to screen in NICU  No - Missed (transfer)  No - missed (equipment down)  No - parent refusal  No - Missed (Other reason) \_\_\_\_\_  Unknown
- d. Final Hearing Screening Completed Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)  Unknown
- e. Final Hearing Screening Right Ear Result  Pass  Refer  Unknown  Unable to test
- f. Final Hearing Screening Left Ear Result  Pass  Refer  Unknown  Unable to test
- g. Family History of Permanent childhood hearing loss?  Yes  No  Unknown
- h. Final Newborn Hearing Test Type (select one)  AABR  AOAE  AABR and AOAE

|   |   |  |
|---|---|--|
| <p><b>74. INFORMANT'S NAME (FIRST MIDDLE LAST)</b></p>  | <p><b>75. RELATION TO CHILD</b></p>               | <p><b>76. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE THIS CHILD A SOCIAL SECURITY NUMBER.</b><br/><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p><b>77. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)</b></p>  | <p><b>78. DATE CERTIFIED (mm/dd/yyyy)</b></p>     | <p><b>79. ATTENDANT AT BIRTH (OTHER THAN CERTIFIER (Name and Title))</b><br/><input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Hospital Staff <input type="checkbox"/> CMN/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other</p> |
| <p><b>80. CERTIFIER (Name and Title)</b> <input type="checkbox"/> Certifier same as Attendant<br/><input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Hospital Staff <input type="checkbox"/> CMN/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other</p> | <p><b>81. PHYSICIAN'S MEDICAL LICENSE NO.</b></p> | <p><b>82. CERTIFIER'S MAILING ADDRESS (street, city, state, zip)</b></p>   |
| <p><b>83. REGISTRAR (Signature)</b></p>   |   | <p><b>84. DATE RECEIVED BY STATE REGISTRAR (mm/dd/yyyy)</b></p>  |