Elhart & St. Joseph Counties Head Start Consortium

Child Birth Record

Child Name ______________________________ Birthdate ____________________

Mother Name ______________________________ Birthdate ____________________

Weight [ ] lb [ ] oz **Length** [ ] **Head** [ ] **Type of Delivery** [ ] **Apgar 1 min.** [ ] **Apgar 5 min.** [ ] **Gestational Age** [ ] **weeks** [ ] **Unknown**

Natural, C-Section, Don't Know

Birth Certificate Number [ ]

Birth Facility [ ] **Facility Type** [ ] **City** [ ] **State** [ ] **Length of Stay** [ ]

Hospital, Birthing Center, Home
Don't Know, Other____________________

Medical Problems [ ]

Anemia, Diabetes, Down Syndrome, Fetal Alcohol, Low Birth Wt., Neonatal Drug, Respiratory, Seizure, Sickle Cell

Describe any complications associated with this delivery (pre-term labor, fetal distress, etc.) [ ]

Did this baby have any problems at birth? [ ]

If so, describe: [ ]

Describe any observable defects [ ]

Did the mother have any health problems during this pregnancy/delivery? [ ]

If so, describe: [ ]

Birth Record Notes

[ ]