Dallas County Clerk's Vitals Division

500 Elm St., Suite #2100
Dallas, Texas 75202
(214) 653-7099

Required Documentation for Home Birth Registration

1. **Parents' Identification**
   The identifying document, with photograph, shall be presented in the following order of preference:
   - A passport or certification of naturalization
   - A military service or military dependent identification card
   - A U.S. government ID card, or national identification card issued by another country
   - A current driver's license or other state identification card
   - An alien registration receipt card
   - An employee or student identification card, with photograph

   [25 TAC §181.26 (d)]

2. **Parent's Worksheet for Child's Birth Certificate (VS-109.1)**

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 (F11-11936)**

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

   - An affidavit (notarized) along with photocopy of ID (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

   - An affidavit (notarized) along with photocopy of ID (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 ID 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
        - An affidavit (notarized) attesting to the mother's place of residence along with a photocopy of ID 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

    - An affidavit (notarized) presented from one person along with photocopy of ID, other than the parents, having knowledge of the pregnancy/birth. [25 TAC §181.26 (c)]

If the birth occurred within the city limits of Dallas, please call the City of Dallas Vital Statistics office at 214-670-3248.

Parent's Worksheet for Child's Birth Certificate

FOR HOSPITAL USE ONLY:

MOTHER MR# _____ **NEWBORN MR#** _____

MEDICAID # _____ **DELIVERING DR** _____ **RM #** _____

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	City	Zip Code

CHILD'S INFORMATION

Time of Birth		Date of Birth	Plurality **(please circle one)**
	Am / Pm		Single / Twin / Triplets / Quadruplets / Quintuplets

Birth Order **(please circle one)**	Number of Infants Born Alive at this Birth? **(please circle one)**
First / Second / Third / Fourth / Fifth	One / Two / Three / Four / Five

PARENT 1 - CURRENT LEGAL NAME ☐ Mother ☐ Father ☐ Parent

First Name	Middle Name	Last Name	Suffix

CHILD'S LEGAL NAME

First Name	Middle Name	Last Name	Suffix

PARENT 1 - RESIDENCE ADDRESS

Residence Address	Apartment Number	State/Foreign Country	County

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ **Yes** ☐ **No**

PARENT 1 - MAILING ADDRESS (If same as residence address, LEAVE THIS SECTION BLANK)

Mailing Address	Apartment Number	State/Foreign Country

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ Yes ☐ No

PARENT 1 - INFORMATION

Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security

Apply for Baby's Social Security?	Did Parent 1 Give up Rights to the Child?	Date Rights Given Up?
☐ Yes ☐ No	☐ Yes ☐ No	

Occupation	Type of Business

Parent 1's Education

- ☐ 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)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

Is Parent 1 of Hispanic Origin?

- ☐ No, not Spanish / Hispanic / Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish / Hispanic / Latina
  Specify_____

What is Parent 1's Race?

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
  (Name of the enrolled or principal tribe)
  _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian_____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
  Specify _____
- ☐ Other _____
- ☐ Unknown

PARENT 1 - HEALTH INFORMATION

Did you receive WIC for this Birth?	Height	Weight Before Pregnancy	Weight At Delivery
☐ Yes ☐ No			

How many cigarettes did you smoke before and during pregnancy?

Three Months Before	Cigs/Day: ____	Packs/Day: ___	**First Three Months**	Cigs/Day: ____	Packs/Day: ___
Second Three Months	Cigs/Day: ____	Packs/Day: ___	**Third Trimester**	Cigs/Day: ____	Packs/Day: ___

PARENT 1 - NAME PRIOR TO FIRST MARRIAGE

First Name	Middle Name	Last Name	Suffix

PARENT 1 - MARITAL STATUS (Please read carefully)

Were you married at the time you conceived this child, at the time of birth, or within 300 days prior to the birth of your child?

☐ Yes (Please skip over the AOP section below and complete Parent 2 sections).

☐ Yes, but I refuse to provide my spouse's name as the parent of my child.
- ☐ Would you like to complete an AOP? (See AOP section below)
- ☐ No, I can provide legal documentation: court order, gestational agreement, or surrogacy (Complete Surrogacy Worksheet on Page 5)

☐ Yes, but the spouse is not the biological parent of my child. (Please complete AOP section).

☐ No- if you are not married, the other parent's name may be listed on the birth certificate only if both parents complete an Acknowledgement of Paternity. (Please complete AOP section)

ACKNOWLEDGEMENT OF PATERNITY (AOP) (An AOP can only be signed by the bio mom/dad or presumed father)

Do you want to complete an Acknowledgement of Paternity?

☐ Yes - If you are or have been married to someone other than the biological parent of this child, or within 300 days before this child's birth, the AOP must include a Denial of Paternity from the husband or former husband to allow the biological parent's information to be listed on the birth certificate. (Please complete Parent 2 Section, which starts on Page 3).

☐ No - Information about the other parent cannot be included on the birth certificate. (Please continue on to Page 4 and finish Parent 1 & IMMTRAC information.)

PARENT 2 - CURRENT LEGAL NAME/INFORMATION ☐ Mother ☐ Father ☐ Parent

Legal First Name	Middle Name	Last Name	Suffix

Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security

Occupation	Type of Business

Parent 2's Education

- ☐ 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)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

Is Parent 2 of Hispanic Origin?

- ☐ No, not Spanish / Hispanic / Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish / Hispanic / Latino
  Specify_____

What is Parent 2's Race?

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
  Specify _____
- ☐ Other _____
- ☐ Unknown

Has Paternity – Genetic Testing Been Done?	Parent 2's Mailing Address	Apartment Number
☐ **Yes** ☐ **No**		

State/Foreign Country/Territory	City/Town/Location	Zip Code / Extension

PARENT 2 - NAME PRIOR TO FIRST MARRIAGE

First Name	Middle Name	Last Name	Suffix

PRESUMED FATHER INFORMATION (Complete ONLY if applicable)

Date of Birth	Social Security

First Name	Middle Name	Last Name	Suffix

Mailing Address	Apartment Number	State/Foreign Country/Territory

City/Town/Location	Zip Code Extension	

PARENT 1 - MEDICAID INFORMATION (Complete ONLY if applicable)

Parent 1's Medicaid Name	Parent 1'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? ☐ **Yes** ☐ **No**

SURROGACY WORKSHEET ADDENDUM

INTENDED PARENT 1 ☐ Mother ☐ Father ☐ Parent

First Name	Middle Name	Last Name	Suffix

INTENDED PARENT 1'S NAME PRIOR TO FIRST MARRIAGE

First Name	Middle Name	Last Name	Suffix

Intended Parent 1's Medicaid Name	Intended Parent 1's Medicaid Number

Intended Parent 1's Marital Status

□ **Never Married** ☐ **Widowed** □ **Widowed** □ **Divorces** □ **Currently Married** □ **Married Refuse Info** □ **Unknown**

INTENDED PARENT 1'S RESIDENCE ADDRESS

Residence Address	Apartment Number	State/Foreign Country	County

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ **Yes** ☐ **No**

INTENDED PARENT 1'S MAILING ADDRESS (If same as residence address, LEAVE THIS SECTION BLANK)

Mailing Address	Apartment Number	State/Foreign Country

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ **Yes** ☐ **No**

INTENDED PARENT 2'S NAME PRIOR TO FIRST MARRIAGE

First Name	Middle Name	Last Name	Suffix

INTENDED PARENT 2

First Name	Middle Name	Last Name	Suffix

Date of Birth	Age	State, Territory, or Foreign Country of Birth	Social Security

Medical Data Worksheet for Child's Birth Certificate

This form to be completed by hospital staff. This data will be used to populate the medical data portion of the birth certificate for the newborn. The medical data is required to be reported within five days of the birth. **[HSC §192.003]**

PATIENT REFERRENCE:

MOTHER MR# _____ **NEWBORN MR#** _____

MOTHER'S NAME _____ **NEWBORN NAME** _____

MEDICAID# _____ **DOB** _____

DELIVERING DR _____ **DATE AOP SENT** _____

MOTHER TRANSFERRED _____ **SOURCE OF PAYMENT FOR DELIVERY** _____

☐ **Born at Facility** ☐ **Born En Route** ☐ **Foundling** ☐ **Home Birth**

Prenatal Care ☐ Yes ☐ No ☐ Unknown

Date of First Visit ____/____/_____

Date of Last Visit ____/____/_____

Total Number of Prenatal Visits for this Pregnancy: _____

Date Last Normal Menses Began ___/___/_____

Pregnancy History

Live births now living (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "**0**".): _____

Live births now dead (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "**0**".): _____

Date of last live birth: ____/_____
MM YYYY

Number of other pregnancy outcomes (Include fetal losses of any gestational age. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy. If **none** enter "**0**".): _____

Date of last other pregnancy outcome: ____/_____
MM YYYY

Infections Present and/or Treated During Pregnancy (check all that apply)

☐ Gonorrhea ☐ Hepatitis B

☐ Syphilis ☐ Hepatitis C

☐ Chlamydia ☐ None of the above

Source of Prenatal Care (check all that apply)

☐ None ☐ Midwife

☐ Hospital Clinic ☐ Other, Specify _____

☐ Public Health Clinic ☐ Unknown

☐ Private Physician

Risk Factors in this Pregnancy (check all that apply)

Diabetes

☐ Prepregnancy (diagnosis prior to this pregnancy)

☐ Gestational (diagnosis in this pregnancy)

Hypertension

☐ Prepregnancy (chronic)

☐ Gestational (PIH, preeclampsia)

☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment

☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination

☐ Assisted reproductive technology

☐ Mother had a previous cesarean delivery
If yes, how many?_____

☐ Antiretrovirals administered during pregnancy or at delivery

☐ None of the above

HIV Test

HIV test done Prenatally ☐ Yes ☐ No ☐ Unknown
(check all that apply)

☐ First Trimester ☐ Third Trimester

☐ Second Trimester ☐ Unknown ☐ None

HIV test done at Delivery ☐ Yes ☐ No ☐ Unknown

Infant tested for HIV at birth ☐ Yes ☐ No ☐ Unknown

SAMPLE

Obstetric Procedures (check all that apply)

- ☐ Cervical cerclage
- ☐ Tocolysis

External cephalic version

- ☐ Successful ☐ Failed
- ☐ None of the above

Characteristics of Labor & Delivery (check all that apply)

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

Maternal Morbidity – Complications associated with Labor & Delivery (check all that apply)

- ☐ Maternal transfusion
- ☐ Third or forth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ None of the above

Was Infant Transferred within 24 hours of Delivery?

☐ No ☐ Yes, Specify Facility _____

Is Infant Living at Time of Report?

☐ Yes ☐ No

Is Infant Being Breastfed at Discharge?

☐ Yes ☐ No

Hepatitis B Immunization given?

☐ Yes ☐ No

Onset of Labor (check all that apply)

- ☐ Premature Rupture of the Membranes [prolonged > =12 hours]
- ☐ Precipitous Labor [< 3 hours]
- ☐ Prolonged Labor [> = 20 hours]
- ☐ None of the above

Method of Delivery

Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

Fetal presentation at birth
☐ Cephalic ☐ Breech ☐ Other, _____

Final route and method of delivery
☐ Vagina/Spontaneous ☐ Vagina/Forceps ☐ Vagina/Vacuum

If cesarean, was a trial of labor attempted? ☐ Cesarean
☐ Yes ☐ No ☐ Unknown

Child's Health Information

Birth Weight _____ Grams, or _____LB. _____OZ.

Obstetric Estimate of Gestation (completed weeks): _____

Child's Sex: ☐ Male ☐ Female ☐ Not yet determined

Apgar Score: at 5 min:_____; (if less than 6) at 10 min:_____

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
- ☐ 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)
- ☐ None of the above

Congenital Anomalies of the Newborn (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
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the above

SAMPLE

TEXAS Health and Human Services | Texas Department of State Health Services

ImmTrac2 Immunization Registry
NEWBORN REGISTRATION FORM

(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth *Newborns only.

Child's Gender: ☐ Male ☐ Female

Mother's First Name

Mother's Maiden Name

Mother's Street Address

Apartment #

Telephone

City

State

Zip Code

County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure important vaccines are not missed.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

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 state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department for public health purposes within their areas of jurisdiction;
- a physician or other health-care provider legally authorized to administer vaccines for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group - MC 1946, P. O. Box 149347, Austin, Texas 78714 - 9347.

Please mark the appropriate box with a ☑ to indicate your choice.

☐ I **GRANT** consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

☐ I **DENY** consent for registration. I wish to EXCLUDE my child's information from the Texas immunization registry.

Parent, legal guardian, or managing conservator: _____
Printed Name:

Date: _____ Signature: _____

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. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

BIRTH REGISTRARS

Please enter newborn client information in the Texas Electronic Registrar and **affirm** that consent has been granted.
DO NOT fax to DSHS. Retain this form in the client's birth record.

Congratulations on the birth of your new Little Texan!

Texas Vital Statistics would like to take this opportunity to answer some most commonly asked questions about birth certificates in Texas.

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. As another option, you can order online at www.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 Parent 1's mailing address as provided on the Parent's Worksheet for Child's Birth Certificate. The entire process usually takes **4-6 weeks** to complete.

When will I receive my baby's Medicaid number?
If you provided answers to "Parent 1's Medicaid Name" and "Parent 1's 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 1's mailing address as provided in the Parent's Worksheet for Child's Birth Certificate. The entire process usually takes **4-6 weeks** to complete.

When do I add my baby to my health insurance?
It's your responsibility to add your baby to your medical insurance. You need to contact your employer's human resources or benefits department regarding their policy to modifying covered dependents. You will need to get with your employer as soon as possible to find out the timeframe of adding your baby to your insurance.