FLORIDA DEPARTMENT OF HEALTH

Florida-Live-Birth-Application-for-Birth-Certificate

DH 511, 04/2016, Rule 64V-1.006, Florida Administrative Code (Obsoletes Previous Editions)

SUMMARY

This document is the Florida Certificate of Live Birth form (DH 511, 04/2016), an administrative record prescribed by Florida Administrative Code Rule 64V-1.006 and authorized by Florida Statutes § 382.0135. It is used by the Florida Department of Health to collect vital statistics, parentage, medical history, and demographic data for a live birth, including optional paternity acknowledgment and Social Security number collection. The form is not a judicial opinion but a standard state vital-records instrument.

OPINION

Screen Consent YesNo Program ConsentYesNo Info. Release YesNo Local File No. 109- 1. CHILD'S NAME (First, Middle, Last, Suffix) 2. SEX 3. DATE OF BIRTH (Month, Day, Year) TYPE IN 4. BIRTH WEIGHT (Enter lbs/ozs OR grams) 5. TIME OF BIRTH (24 hr.) 6. COUNTY OF BIRTH BLACK INK lbsozsgrams 7. PLACE WHERE BIRTH OCCURRED (Check one) HospitalFreestanding 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/ 10. CERTIFIER'S SIGNATURE AND TITLE 11. DATE SIGNED (Month, Day, Year) ATTENDANT M.D.D.O.C.N.M.L.M.Hosp. Admin. Other (Specify) 12. ATTENDANT'S NAME AND TITLE 13. DATE FILED BY REGISTRAR M.D.D.O.C.N.M.L.M. (Month, Day, Year)(Reg.Initials) Other (Specify) 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 16. MOTHER'S/PARENT'S DATE OF BIRTH (Month, Day, Year) 17. MOTHER'S/PARENT'S BIRTHPLACE (State, Territory or Foreign Country) MARRIED? YesNo 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? YesNo 18h. MOTHER'S/PARENT'S MAILING ADDRESS Check here if same as Residence, or Street and Number: Apt. No. City: State: Zip Code: 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) I certify that the personal information provided on this certificate is correct to the best of my knowledge. 22. SIGNATURE of Parent 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. (Date)(Date) (Witness 1)(Witness 2)(Witness 1)(Witness 2) STATE OF FLORIDA, COUNTY OF STATE OF FLORIDA, COUNTY OF SWORN TO OR AFFIRMED BY SWORN TO OR AFFIRMED BY (Print Mother's Name) (form and number of ID) (form and number of ID) day of_____, 20___, by Notary Public - State of Florida Notary Public - State of Florida my commission expires:my commission expires: 24.

SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? 25a. MOTHER'S/PARENT'S SOCIAL SECURITY NUMBER 25b. FATHER'S/PARENT'S SOCIAL SECURITY NUMBER YesNo 26. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY 27. DID MOTHER/PARENT GET WIC FOOD FOR HERSELF MedicaidPrivate InsuranceSelf-payOther (Specify) DURING THIS PREGNANCY? YesNo 28a. WAS MOTHER/PARENT TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

YesNo (If Yes, specify name of facility transferred from) 28b. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? YesNo (If Yes, specify name of facility transferred to) 29a. IS INFANT LIVING AT TIME OF REPORT? 29b. DATE OF DEATH (Month, Day, Year) 29c. COUNTY OF DEATH (If No, complete items 29b-29c) YesNoInfant transferred, status unknown CHILD MOTHER / PARENT FATHER / PARENT PARENT PATERNITY CERTIFICATE OF LIVE BIRTH FLORIDA FOR ADMINISTRATIVE USE ONLY PATERNITY ACKNOWLEDGEMENT (Print Father's Name) / / (Father's Signature) (Mother's Signature) thisday of IDENTIFIED BY: IDENTIFIED BY: thisday of ADMIN DH 511, 04/2016, Rule 64V-1.006, Florida Administrative Code (Obsoletes Previous Editions) 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):MexicanPuerto RicanCubanOther 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.)

WhiteBlack or African AmericanAmerican Indian or Alaskan Native (Specify tribe) Asian IndianChineseFilipinoJapaneseKoreanVietnameseOther Asian (Specify) Native HawaiianGuamanian or ChamorroSamoanOther Pacific Isl. (Specify)Other (Specify) 32.

EDUCATION (Specify highest degree or level of school completed at time of delivery.) College degree 8th or lessHigh school but no diplomaHigh school diploma or GEDCollege but no degree(Specify): AssociateBachelor'sMaster'sDoctorate 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):MexicanPuerto RicanCubanOther 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.)

WhiteBlack or African AmericanAmerican Indian or Alaskan Native (Specify tribe) Asian IndianChineseFilipinoJapaneseKoreanVietnameseOther Asian (Specify) Native HawaiianGuamanian or ChamorroSamoanOther Pacific Isl. (Specify)Other (Specify) 35. EDUCATION (Specify highest degree or level of school completed at time of delivery.) College degree 8th or lessHigh school but no diplomaHigh school diploma or GEDCollege but no degree(Specify): AssociateBachelor'sMaster'sDoctorate PREGNANCY 36a.

PRENATAL CARE RECEIVED? 36b. DATE OF FIRST PRENATAL VISIT (Mo, Day, Yr) 36c. DATE OF LAST PRENATAL VISIT (Mo, Day, Yr) 36d. PRENATAL VISITS HISTORY YesNo (If No, skip to # 37)Number 37. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) 38. MOTHER'S/PARENT'S HEIGHT 39a-b. MOTHER'S/PARENT'S WEIGHT (in pounds) feet/inches prepregnancy at delivery 40. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY?

41. ALCOHOL USE DURING PREGNANCY? For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If NONE, enter "0".YesNo Average number of cigarettes or packs of cigarettes smoked per day. 42a-b. PREVIOUS LIVE BIRTHS (Do not include this child) 42c. DATE OF LAST LIVE BIRTH (Month, Year) # of cigarettes # of packs Three Months before PregnancyOR Number Now Living Number Now Dead First Three Months of PregnancyOR 42d.

OTHER PREGNANCY OUTCOMES 42e. DATE OF LAST OTHER OUTCOME (Month, Year) Second Three Months of PregnancyOR (Spontaneous or induced losses, or ectopic pregnancies) Third Trimester of PregnancyOR Total Number MEDICAL 43. RISK FACTORS IN THIS PREGNANCY (Check all that apply) ANDDiabetes - Prepregnancy (Diagnosis prior to this pregnancy)Diabetes - Gestational (Diagnosis in this pregnancy) HEALTHHypertension - Prepregnancy (Chronic) Hypertension - Gestational (PIH, preeclampsia)Hypertension - Eclampsia INFORMATIONPrevious preterm birthOther 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) GonorrheaSyphilisChlamydiaHepatitis BHepatitis C Other (Specify) None 45. OBSTETRIC PROCEDURES (Check all that apply) Cervical cerclageExternal 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 laborAugmentation of laborSteroids (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 0 C (100.4 0 F) 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:CephalicBreechOther (Specify) B.Final route and method of delivery (Check one):Vaginal/SpontaneousVaginal/ForcepsVaginal/Vacuum # Cesarean (Was a trial of labor attempted? _____ Yes _____ No) E. S. 49. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply) Maternal transfusionThird or fourth degree perineal lacerationRuptured uterusUnplanned hysterectomyAdmission to intensive care unit Unplanned operating room procedure following deliveryOther (Specify) None 50.

OBSTETRIC ESTIMATE OF GESTATION 51a. PLURALITY (Single, Twin, etc.) 51b. IF NOT SINGLE BIRTH (Born First, Second, etc.) completed weeks 52. WAS INFANT BEING BREASTFED DURING THE PERIOD BETWEEN BIRTH 53. APGAR SCORE AND DISCHARGE FROM THE HOSPITAL?YesNo5 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.) State of NICU AdmissionNewborn given surfactant replacement therapy Florida Antibiotics received by the newborn for suspected neonatal sepsisSeizure or serious neurologic dysfunction Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) Department Hyaline Membrane Disease/RDSOther (Specify) None of Health 55.

CONGENITAL ANOMALIES (Check all that apply) AnencephalyMeningomyelocele/Spina bifidaCyanotic congenital heart diseaseCongenital diaphragmatic hernia Vital

OmphaloceleGastroschisisLimb reduction defect (excluding congenital amputation and dwarfing syndromes) Statistics Cleft Lip with or without Cleft PalateCleft Palate alone Down Syndrome (Karotype: _____confirmed _____ pending)Suspected chromosomal disorder (Karotype: _____confirmed _____ pending) HypospadiasOther (Specify) None 56.

MOTHER'S/PARENT'S MEDICAL RECORD NUMBER 57. NEWBORN MEDICAL RECORD NUMBER INFORMATION FOR MEDICAL AND HEALTH USE ONLY NEWBORN FATHER / PARENT 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.

MOTHER / PARENT