**Birth Information**

**Mother’s Maiden Name**

|  |  |  |
| --- | --- | --- |
| **Last** | **First** | **Middle** |

**Father’s Name**

|  |  |  |
| --- | --- | --- |
| **Last** | **First** | **Middle** |

**Foster Parent/Guardian**

**Names of brothers and sisters**

**Hospital (birth)**

**Birth Weight**   **lbs.**   **oz. Length**   **inches**

**APGAR Score**   **Gestation Age**   **Weeks**

**Diagnosis**

**Doctor**

**Complications at Birth**

**Prenatal Medical Care of Mother:**

  **Regular**   **Erratic**   **Absent**

**When was Prenatal Care Begun?**

**Was Oxygen Used for Baby After Delivery?** [ ]  **Yes** [ ]  **No**

**Blood type of child**

 **Name**   **DOB**

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*Contact the Northern Regional Center at 1-866-640-4106*

Website: www.northernregionalcenter.org

Email: specialneedsinfo@co.marathon.wi.us

Adapted from *Medical Passport* (unpaged) by the Indiana State Department of health Children’s Special Health Care Services, 1-800-475-1355, printed (n.d.), Project MCJ-18I523-02.