Birth Certificates in Texas

You Have to Prove:

1. Your pregnancy: This has to be a notarized affidavit from a medical provider.
2. That the infant was born alive: A medical record for your baby or a letter from a provider.
3. That the infant was born in the registration district: If your baby was born at home, you just need proof of residency for this (utility bill, rent receipt etc.).
4. That the infant was born on the date stated: A medical record from a licensed institution.

Use of Affidavits

For one of the above cases you can use an affidavit. Let's say you didn't take your baby to a doctor on the day he or she was born. In that case, you may want to ask a friend or family member to sign an affidavit stating that the infant was in fact born on that day at that time at your residence. You will have to get that affidavit notarized. Most banks will notarize free of charge, but places like UPS may offer notary services for a small fee, too. Be as specific as possible on the affidavit (even to the point of being redundant) to avoid having to do it over. For example, the affidavit shouldn't just list the date and time the baby was born but also the names and addresses of the parent and the birth place of the baby.

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

Birth Worksheet for Child's Birth Certificate

This birth certificate worksheet is a tool to help your facility collect the necessary information for reporting births in TxEVER, the Texas Electronic Vital Events Registrar. Medical personnel should complete this worksheet. The information you report in TxEVER is used to create a child's birth certificate. Ensure the information you report is correct so that an accurate birth certificate is created. The birth certificate is a legal document that the child will use throughout their life to prove their identity, birthplace, and parentage. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Newborn

Newborn Information

Record Type:	Plurality:	Birth Order:	Is Child Unnamed?
☐ Born at this facility ☐ Born en-route to facility ☐ Foundling/ Safe Haven ☐ Home birth-Intended ☐ Home birth-Intent unknown ☐ Home birth-Unintended ☐ Surrogacy-1 Parent ☐ Surrogacy-2 Parent	☐ Single ☐ Twins ☐ Triplets ☐ Quadruplets ☐ Quintuplets ☐ Sextuplets ☐ Septuplets ☐ Eight ☐ Nine ☐ Ten ☐ Unknown	☐ First ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ Sixth ☐ Seventh ☐ Eighth ☐ Ninth ☐ Tenth ☐ Conjoined	☐ Yes ☐ No

First Name:	Middle Name:	Last Name:	Suffix:

Date of Birth:	Time of Birth:	Sex:	Infant's Medical Record Number:
____ / ____ / ______	_ _: _ _ ☐ AM ☐ PM	☐ Female ☐ Male ☐ Unknown/ Not yet Determined	

SSN Information

Parents Authorize Release of Information to Social Security Administration to Issue this Child a SSN:
☐ Yes
☐ No
☐ Unknown

Mother's Information

Title Preference:	Legal First Name:	Legal Middle Name:	Legal Last Name:
☐ Mother ☐ Father ☐ Parent			

Legal Suffix:	Medical Record Number:

Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

Facility Information & Place of Birth

Name: ☐ Facility Name: ☐ Other	Facility Name Other (Specify):	Type: ☐ Clinic/Doctor's Office ☐ Home Birth Intended ☐ Home Birth Intent Unknown ☐ Home Birth Unintended ☐ Hospital ☐ Licensed Birthing Center ☐ Other ☐ Unknown	Type Other Specify:
Address:	Apt:	State:	County:
Local:	City/Town:	Zip:	Zip Ext:

Mother

Mother's Name Prior to First Marriage

☐ Same as Mother's Legal Name?

First Name:	Middle Name:	Last Name:	Suffix:

Mother's Information

Date of Birth: / /	Age at Child's Birth:
Birthplace: (Click Checkbox to Filter Foreign Countries Only)	SSN:
Marital Status: ☐ Never Married ☐ Married ☐ Married, Husband Info Refused ☐ Divorced ☐ Widowed ☐ Not Stated/Unknown	Married Within 300 Days? ☐ Yes ☐ No ☐ Yes, but refusing presumed father information ☐ Unknown
AOP Involved? ☐ Yes ☐ No ☐ Yes - Common Law	Date Acknowledgement of Paternity Signed:
Did Mother Relinquish Rights to Child? ☐ Yes ☐ No ☐ Unknown	Mother's Relinquish Date: / /
Paternity Genetic Testing? ☐ Not done ☐ Has Determined Biological Father	

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

Birth Worksheet for Child's Birth Certificate

Mother's Miscellaneous Information

Education Level:
- ◻ 8th Grade or Less
- ◻ 9th-12th Grade No Diploma
- ◻ High School Graduate or GED Completed
- ◻ Some College Credit, No Degree
- ◻ Associate Degree (E.G., AA, AS)
- ◻ Bachelor's Degree (BA, AB, BS)
- ◻ Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- ◻ Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- ◻ Unknown/Not stated

Occupation:	Kind of Business or Industry:

Email:

Mother's Residence Address Information

◻ Withheld by Request on AOP

Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:

Inside City Limits:
◻ Yes ◻ No ◻ Unknown

Mother's Mailing Address Information

◻ Same as Residence?

Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:

Mother Demographics

Mother's Ethnicity

- ◻ No, Not Spanish/Hispanic/Latina
- ◻ Yes, Mexican, Mexican American, Chicana
- ◻ Yes, Puerto Rican
- ◻ Yes, Cuban
- ◻ Yes, Other Hispanic (Specify: ______________________)
- ◻ Unknown

Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

Mother's Race

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the Enrolled or Principal Tribe: ____________________)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify: ____________________)
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify: ____________________)
- ☐ Other (Specify: ____________________)
- ☐ Unknown

Father

Father's Legal Name

Title Preference: ☐ Mother ☐ Father ☐ Parent

First Name:	Middle Name:	Last Name:	Suffix:

Father's Maiden Name

☐ Same as Father's Legal Name?

First Name:	Middle Name:	Last Name:	Suffix:

Father's Information

Date of Birth: __/__/____	Age:
Birthplace: (Click Checkbox to Filter Foreign Countries Only)	SSN: ______-_____-______

TEXAS
Health and Human Services

Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

Father's Miscellaneous Information

Education Level:
- ☐ 8th Grade or Less
- ☐ 9th-12th Grade No Diploma
- ☐ High School Graduate or GED Completed
- ☐ Some College Credit, No Degree
- ☐ Associate Degree (E.G., AA, AS)
- ☐ Bachelor's Degree (BA, AB, BS)
- ☐ Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- ☐ Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- ☐ Unknown/Not stated

Occupation:	Kind of Business or Industry:

Father's Mailing Address Information

☐ Withheld by Request on AOP	☐ Same as Mother's Mailing?		
Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:

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

Birth Worksheet for Child's Birth Certificate

Father Demographics

Father's Ethnicity	Father's Race
☐ No, Not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Other Hispanic (Specify) ☐ Unknown ☐ Refused	☐ White ☐ Black or African-American ☐ American Indian or Alaska Native (Name of the Enrolled or Principal Tribe) ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (Specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Specify) ☐ Other (Specify) ☐ Unknown ☐ Refused

This tab displays when AOP = yes on Mother's Tab and marital status = yes

Presumed Father

Presumed Father's Legal Name

First Name:	Middle Name:	Last Name:	Suffix:

Presumed Father's Information

Date of Birth: _____/_____/_______	SSN: ______ - ____ - _________

Presumed Father's Mailing Address Information

☐ Withheld by Request on AOP	☐ Same as Mother's Mailing?		
Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:

Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

This tab displays when record type = surrogacy 1 parent/surrogacy 2 parent

Intended Mother

Intended Mother's Current Legal Name

Title Preference: □ Mother □ Father □ Parent

First Name:	Middle Name:	Last Name:	Suffix:

Intended Mother's Name Prior to First Marriage

Same as Intended Mother's Legal Name? □ Yes □ No

First Name:	Middle Name:	Last Name:	Suffix:

Mother's Information

Date of Birth: ___/___/_____	Age:	Birthplace: (Click Checkbox to Filter Foreign Countries Only)

SSN:

Marital Status:
- □ Never Married
- □ Married
- □ Married, Husband Info Refused
- □ Divorced
- □ Widowed
- □ Not Stated/Unknown

Intended Mother's Medicaid Information

Intended Mothers Medicaid Chip Name:	Intended Mothers Medicaid Chip Number:

Intended Mother's Residence Address Information

Address:	Apt:	State/Country:	County:
City/Town:	Zip:	Zip Ext:	Inside City Limits:

Intended Mother's Mailing Address Information

□ Same as Residence?

Address:	Apt:	State/Country:	County:
City/Town:	City (Other):	Zip:	Zip Ext:

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

Birth Worksheet for Child's Birth Certificate

Intended Father

Intended Father's Legal Name

Title Preference: □ Mother □ Father □ Parent

First Name:	Middle Name:	Last Name:	Suffix:

Father's Maiden Name

Same as Intended Father's Legal Name? □ Yes □ No

First Name:	Middle Name:	Last Name:	Suffix:

Intended Father's Information

Date of Birth: ____ / _____ / ________	Age:	Birthplace (Click Checkbox to Filter Foreign Countries Only):	SSN:

Mother Medical - 1

General

Mother Transferred for Delivery? □ YES □ NO	If YES, from What Location: □ OTHER (Option to Search All Locations Available in TxEVER)

Mother Transfer Facility - Other:

Principal Source of Payment:
- □ PRIVATE INSURANCE (BLUE CROSS/ BLUE SHIELD, AETNA, ETC.)
- □ MEDICAID/CHIP (PENDING OR NOT)
- □ SELF PAY
- ~~□ OTHER~~
- □ INDIAN HEALTH SERVICE
- □ CHAMPUS/TRICARE
- □ OTHER GOVERNMENT (FEDERAL, STATE, LOCAL)

Principal Source of Payment – Other (Specify):

Did Mother Get WIC Food for Herself during This Pregnancy? □ Yes □ No

Mother's Medicaid Chip Name:	Mother's Medicaid Chip Number:

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Birth Worksheet for Child's Birth Certificate

Cigarettes Information

Did Mother Smoke Cigarettes before or during Pregnancy? □ Yes □ No

Did Mother Report in Packs? □

Did Mother Report in Cigarettes? □

	# of Cigarettes Per Day	# of Packs Per Day
Three Months before Pregnancy		
First Trimester		
Second Trimester		
Third Trimester		

Mother's Health Information

Mother's Weight at Delivery (lbs):	Mother's Pre-Pregnancy Weight (lbs):
Mother's Height (Feet/Inches):	Date Last Normal Menses Began:

HIV Testing

HIV Test Done Prenatally? □ Yes □ No □ Unknown

Check All that Apply:
□ First Trimester
□ Second Trimester
□ Third Trimester
□ None
□ Unknown

HIV Test Done at Delivery? □ Yes □ No □ Unknown

Infant Tested for HIV at Birth? □ Yes □ No □ Unknown

Birth Worksheet for Child's Birth Certificate

Mother Medical – 2

Pregnancy History

Number of Previous Live Births Now Living (Do Not Include This Child):

Number of Previous Live Births Now Dead:

Date of Last Live Birth: _____ / _____ / ________

Number of Other Pregnancy Outcomes:

Date of Last Other Pregnancy Outcome: _____ / _____ / ________

Prenatal

Did Mother Receive Prenatal Care? ▫ Yes ▫ No ▫ Unknown

Date of First Prenatal Care Visit: _____ / _____ / ________

Date of Last Prenatal Care Visit: _____ / _____ / ________

Total Number of Prenatal Care Visits; If None, Enter '0':

Source of Prenatal Care Visits
- ▫ Hospital
- ▫ Public Health Clinic
- ▫ Private Physician
- ▫ Midwife
- ▫ Other: Specify
- ▫ None
- ▫ Unknown
  - MVR (Missing Value Reason)
    - ▫ Refused
    - ▫ Not Obtainable
    - ▫ Sought But Not Obtainable

Method of Delivery

Was Delivery with Forceps Attempted but Unsuccessful? ▫ Yes ▫ No

Was Delivery with Vacuum Extraction Attempted but Unsuccessful? ▫ Yes ▫ No

Fetal Presentation at Birth?
- ▫ Cephalic
- ▫ Breech
- ▫ Other

Final Route & Method of Delivery?
- ▫ Vaginal/Spontaneous
- ▫ Vaginal/Forceps
- ▫ Vaginal/Vacuum
- ▫ Cesarean (Final Route)
- ▫ Unknown

If Cesarean, Was a Trial of Labor Attempted? ▫ Yes ▫ No

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

Birth Worksheet for Child's Birth Certificate

Mother Medical - 3

Exposure/Infections Present/Treated During Pregnancy

Exposure/Infections Present/Treated during Pregnancy (Check All that Apply):

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Unknown
  Infection MVR:
  - o Refused
  - o Not Obtainable
  - o Sought, But Not Obtainable
- ☐ None of the Above

Risk Factor in this Pregnancy

Risk Factors in this Pregnancy (Check All that Apply):

- ☐ Diabetes (Select One of the Following)
  - ☐ Pre-Pregnancy (Diagnosis Prior to this Pregnancy)
  - ☐ Gestational (Diagnosis in this Pregnancy)
- ☐ Hypertension (Select One of the Following)
  - ☐ Pre-Pregnancy (Chronic)
  - ☐ Gestational (PIH, Preeclampsia)
  - ☐ Eclampsia
- ☐ Previous Preterm Birth
- ☐ Other Previous Poor Pregnancy Outcome (Includes Perinatal Death, Small for Gestational Age/Interuterine Growth Restricted Birth)
  - ☐ Perinatal Death
  - ☐ Small for Gestational Age
  - ☐ Intrauterine Growth Restriction
  - ☐ Other (Specify) ___________
- ☐ Pregnancy Resulted from Infertility Treatment (Check All that Apply):
  - ☐ Fertility-Enhancing Drugs
  - ☐ Artificial Insemination
  - ☐ Intrauterine Insemination
  - ☐ Assisted Reproductive Technology - Vitro Fertilization (IVF)
  - ☐ Assisted Reproductive Technology - Gamete Intrafallopian Transfer (GIFT)
  - ☐ Other (Specify) ___________
- ☐ Mother Had a Previous Cesarean Delivery?
  - ☐ If selected, how many? _________
- ☐ Antiretrovirals Administered during Pregnancy or at Delivery
- ☐ Cholecystitis
- ☐ Prior Classical Cesarean
- ☐ Prior Myomectomy
- ☐ None of the Above
- ☐ Unknown (Select One)
  - ☐ Refused
  - ☐ Not Obtainable
  - ☐ Sought, But Not Obtainable

Birth Worksheet for Child's Birth Certificate

Mother Medical – 4

Obstetric Procedures

Obstetric Procedures (check all that apply):

□ Cervical Cerclage

□ External Cephalic Version (choose one):

  □ Successful

  □ Failed

□ Tocolysis

□ None of the Above

Onset of Labor

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

  □ Refused

  □ Not Obtainable

  □ Sought But Not Obtainable

Characteristics of Labor & Delivery

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 the Mother Prior to Delivery

□ 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 of More of the Following Action Was Taken: In-Utero Resuscitative Measures, Further Fetal Assessment, or Operative Delivery

□ Epidural or Spinal Anesthesia during Labor

□ None of the Above

  □ Other Complication Not Listed

  □ No Complications Determined

Maternal Morbidity

Complication Associated with Labor and Delivery (Check all that apply):

□ Maternal Transfusion

□ 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

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Birth Worksheet for Child's Birth Certificate

Newborn Medical - 1

General

Is Infant Living at Time of Report? □ Yes □ No □ Infant Transferred, Status Unknown	Is Infant Being Breast Fed, Even Partially? □ Yes □ No
Obstetric Estimate of Gestation (completed weeks):	
Apgar Score (at 5 min.): 1 - 10: □ Not Taken □ Unknown	Apgar Score (at 10 min.): 1 - 10: □ Not Taken □ Unknown
Was Infant Transferred within 24 Hours of Delivery? If YES Where:	□ Yes □ No
Infant Transfer Facility - Other:	Was Infant Vaccinated with Hepatitis B Vaccine? □ Yes □ No □ Unknown □ Information Unavailable
Infant Primary Care Physician:	

Child's Weight Information

Grams:	Pounds:	Ounces:

ImmTrac Consent

Please Indicate the Parent's Choice Regarding Consent for ImmTrac Participation. The Birth Registrar Will be Required to Affirm that this Information Accurately Reflects the Parent's Choice.

If the Parent Has Not Yet Been Offered the Option to Consent for ImmTrac Participation, You May Skip this Section and Answer at a Later Time. This Section Must Be Completed for Legal Release of the Birth Registration.

□ Parent Has GRANTED CONSENT for ImmTrac Participation by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT GRANTED Option.

□ Parent Has DENIED CONSENT for ImmTrac Participation (Requested Exclusion) by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT DENIED Option.

□ Parent Has Not Signed a Properly Completed DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2).

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

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 2

Abnormal Conditions	Congenital Anomalies
Abnormal Conditions of 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 Requiring Intervention) ☐ None of the Above	Congenital Anomalies (Check All that Apply): ☐ Anencephaly ☐ Meningomyelocele/Spina Bifida ☐ Congenital Diaphragmatic Hernia ☐ Gastroschisis ☐ Down Syndrome: o Karyotype Confirmed o Karyotype Pending ☐ Suspected Chromosomal Disorder: o Karyotype Confirmed o Karyotype Pending ☐ Cleft Lip with Cleft Palate ☐ Cleft Palate Alone ☐ Cyanotic Congenital Heart Disease ☐ Omphalocele ☐ Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes) ☐ Hypospadias ☐ None of the Above

Certification

Attendant Information

First Name:	Middle Name:	Last Name:
Title: ☐ MD ☐ Midwife ☐ DO ☐ CNM ☐ Attendant ☐ Facility Administrator/Designee ☐ Other	Other (Specify):	
Address:	Apt:	State/Country:
City/Town:	Zip:	Zip Ext:
NPI:	License Number:	

Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

Certifier Information

☐ Certifier Same as Attendant?		
First Name:	Middle Name:	Last Name:
Title: ☐ MD ☐ Midwife ☐ DO ☐ CNM ☐ Attendant ☐ Facility Administrator/Designee ☐ Other	Other (Specify):	
Address:	Apt:	State/Country:
City/Town:	Zip:	Zip Ext:
Date Certified:		

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.

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

ImmTrac2 Immunization Registry
(RECIÉN NACIDO) FORMULARIODE REGISTRO

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a) **Segundo Nombre del Niño(a)**

__/__/____ *Solo recién nacidos. **Género:** ☐ **Masculino** ☐ **Femenino**

Fecha de Nacimiento del Niño(a)

Nombre de la Madre **Apellido de Soltera de la Madre**

Dirección de la Madre, Calle **Apartamento #** **Teléfono**

Ciudad **Estado** **Código Postal** **Condado**

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menores de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac2. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud de Texas (DSHS) le anima a que participe voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac2 y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714 - 9347.

Favor de marcar la caja ☑ indicando la selección de su preferencia.

☐ YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño(a) en el registro de inmunización de Texas.

☐ YO **NIEGO** el consentimiento para registrarlo. Deseo **EXCLUIR** la información de mi niño(a) del registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: ____________________
Escriba con letra de molde

Fecha: __________ Firma: ____________________

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a *http://www.dshs.texas.gov* para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac2 del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (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.