APPENDIX F

PARENT INFORMATION FORM A

A parent of a newborn, who transfers the newborn to a "qualified person" at an "appropriate location" pursuant to RCW 13.34, is not required to provide ANY identifying information in order to transfer the newborn. The intent of this form is to provide an opportunity for the parent to anonymously provide information about the newborn and his/her family medical history.

Parent unwilling to provide information:	**check here** ☐

TRANSFER INFORMATION			
Date Newborn Transferred:	**Fire Department:**	**Trauma ID Band Number:**	
DELIVERY INFORMATION			
Date and time of birth	Date:	Time:	
Place of birth	☐ Hospital ☐ Home	☐Other:	
Delivered by *(If not hospital delivery)*	☐ Midwife ☐ Mother	☐ Father/family/friend	
Position at birth	☐ Head first ☐ Bottom first	☐ Other:	
Cried at birth	☐ Soon after birth Right away ☐ Delayed, but soon	☐ Other: Seconds after birth: ____ Minutes after birth: ____	
Baby moving arms/legs at birth?	☐ Yes ☐ No		
Baby's coloring shortly after birth	☐ Pink lips and chest, hands and feet ☐ Pink lips and chest with bluish hands and feet	☐ Bluish lips and chest ☐ Not blue but very pale	☐Other:
Placenta *(afterbirth)* **delivered within 10-15 minutes after baby?**	☐ Yes ☐ No If no, when?		
LABOR INFORMATION			
Date/time mother's water broke	Date:	Time:	
What color was the fluid?	☐ Clear ☐ Greenish or brownish ☐ Other		
Any odor to the fluid?	☐ Yes (*describe*)	☐ No	
Date/time contractions *(labor pains)* **started**	Date:	Time:	
PREGNANCY INFORMATION			
How far along was the pregnancy?	_____ Months or weeks_____ or date of last period _____		
Mother's age no exact age?	☐ Under 17 years old ☐ 17 - 35 years old ☐ Over 35 years old		
Prenatal care?	☐ Yes ☐ No		
Other pregnancies?	# of pregnancies: ____ Born alive: ____ Premature births (*more than 3 weeks early*): ____	Low birth weight (*under 5½ lbs*): ____ Stillborn: ____ Miscarried/abortions: ____	
Complications of this pregnancy? (*Bleeding before labor, high blood pressure, high weight gain, infections, morning sickness more than 3 months, etc.*)	Describe:		
Complications of past pregnancies?	Describe:		

Substance use during pregnancy	☐ Alcohol ___Drinks/day *for* ___ Months of pregnancy	☐ Tobacco ___Packs/day *for* ___ Months of pregnancy	☐ Prescription drugs Names:	☐ Other drugs (*street drugs*) Names:
PARENTS' MEDICAL HISTORY INFORMATION				
Personal or family history of	Mother:	Father:	Don't know:	
• **Diabetes**	☐	☐	☐	
• **High blood pressure**	☐	☐	☐	
• **Heart disease**	☐	☐	☐	
• **Lung disease** (*asthma, etc.*)	☐	☐	☐	
• **Allergies**	☐ *(List allergies and reactions):*	☐ *(List allergies and reactions):*	☐ *(List allergies and reactions):*	
• **Sexually transmitted diseases** *(HIV, herpes, gonorrhea, etc.)*	☐	☐	☐	
• **Depression or other mental illness**	☐	☐	☐	
• **Glaucoma or other eye problems**	☐	☐	☐	
• **Cancer**	☐	☐	☐	
• **Hearing problems**	☐	☐	☐	
• **Hemophilia or bleeding problems**	☐	☐	☐	
• **Cystic fibrosis**	☐	☐	☐	
• **Muscular dystrophy**	☐	☐	☐	
• **Huntington's disease**	☐	☐	☐	
• **Down syndrome/other mental retardation**	☐	☐	☐	
Personal or family history of birth defect *(heart, cleft lip/palate, etc.)*	☐ Mother *(Please describe)*	☐ Father *(Please describe)*	☐ Don't know *(Please describe)*	
Ethnic background *(this can sometimes provide important health information)*	Mother:	Father	Don't know	
• **African American**	☐	☐	☐	
• **European (Ashkenazi)**	☐	☐	☐	
• **Jewish**	☐	☐	☐	
• **Italian/Greek/Middle Eastern**	☐	☐	☐	
• **Latino/Hispanic/Puerto Rican**	☐	☐	☐	
• **Native American**	☐	☐	☐	
• **Southeast Asian/Taiwanese /Chinese/ Filipino**	☐	☐	☐	
• **Pacific Islander**	☐	☐	☐	
Any other medical or family history information that you think might be important in your baby's future?				

Return to: Newborn Safety/Adoptions Program Manager Children's Administrative Headquarters
Department of Social and Health Services PO Box 45710 Olympia WA 98504-5710

APPENDIX F

Descriptions and Characteristics of Birth Family				
	Mother	**Father**	**Sibling of Newborn**	**Other – Identify Relationship**
Height				
Weight				
Age *(at time of newborn's birth)*				
Build/Bone Structure				
Complexion color *(fair, medium, dark, olive, light brown)*				
Hair color				
Hair texture				
Eye color				
Right or Left handed				
Blood type				
Education *(to date)*				
Glasses worn? If yes, what for what condition?				
Acne? Age at onset? Treatment?				
Distinguishing characteristics *(e.g., birthmarks, scars, tattoos)*				
Occupation				
Talents / hobbies / skills				
Family Religion				
Addictions *(Drug, Alcohol, Tobacco, etc.)*				
Deceased • **Age** • **Cause of Death**				

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APPENDIX F

Dear Parent:

You may want to write a message to your newborn. If you do, we will pass this message on so that your child may some day read it.

Date Newborn Transferred:	Fire Department:	Trauma ID Band Number:

Parent's Message To Newborn:

This is a thoughtful gift for your child, and will stay with your child.

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