

This is page two of two of the Target Child Identification and Birth Outcomes

Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)			Date of Intake (Month/Day/Yr)								

Biological Parent's Involvement with Target Child

(Complete for biological parent, not PCI, who lives in or outside of the household.)

<p>17. Is Parent Emotionally Involved with Child? <i>(e.g. talks to child, plays with child, loves child, etc.)</i></p> <p><input type="checkbox"/> 1. Very involved</p> <p><input type="checkbox"/> 2. Somewhat involved</p> <p><input type="checkbox"/> 3. Not involved at all</p>	<p>18. Is Parent Physically Involved in Care of Child? <i>(e.g. feeds, changes, diapers, bathes child, etc.)</i></p> <p><input type="checkbox"/> 1. Very involved</p> <p><input type="checkbox"/> 2. Somewhat involved</p> <p><input type="checkbox"/> 3. Not involved at all</p>	<p>19. Is Parent Financially Involved in Care of Child? <i>(e.g. contributes \$ to care of child)</i></p> <p><input type="checkbox"/> 1. Very involved</p> <p><input type="checkbox"/> 2. Somewhat involved</p> <p><input type="checkbox"/> 3. Not involved at all</p>
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Optional Items *(Local Use Only)*

<p>20. Where Received Prenatal Services?</p> <p><input type="checkbox"/> 1. Health Clinic</p> <p><input type="checkbox"/> 2. Private Ob/Gyn</p> <p><input type="checkbox"/> 3. Hospital</p> <p><input type="checkbox"/> 4. Other Specify _____)</p>	<p>21. Apgar Score</p>	<p>22. Parity</p>	<p>23. Gravidity</p>
<p>24. Were any Birth Defects Identified at Birth? <i>(Check all that apply)</i></p> <p><input type="checkbox"/> 1. Mental retardation</p> <p><input type="checkbox"/> 2. Developmental disability</p> <p><input type="checkbox"/> 3. Physical disability or other abnormality</p> <p><input type="checkbox"/> 4. Other <i>(Specify _____)</i></p> <p><input type="checkbox"/> 5. None</p>	<p>25. Type of Delivery</p> <p><input type="checkbox"/> 1. Vaginal</p> <p><input type="checkbox"/> 2. Cesarean</p> <p><input type="checkbox"/> 3. Still birth</p> <p><input type="checkbox"/> 4. Spontaneous abortion</p>		
<p>26. Where Baby was Delivered?</p> <p><input type="checkbox"/> 1. Hospital</p> <p><input type="checkbox"/> 2. Clinic</p> <p><input type="checkbox"/> 3. Emergency Room</p> <p><input type="checkbox"/> 4. At home</p> <p><input type="checkbox"/> 5. Other <i>(Specify _____)</i></p>	<p>27. Feeding Method</p> <p><input type="checkbox"/> 1. Breast</p> <p><input type="checkbox"/> 2. Bottle</p> <p><input type="checkbox"/> 3. Both</p>	<p>28. Was child born with positive toxicology?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	