

Pregnancy Outcome Form ----- The California School Age Families Education (Cal-SAFE) Program

The information in this box is for local use, and will not be transmitted to the state

Student name: Last _____ First _____ MI _____

Address: Street _____ City _____ Zip Code _____

<p>1. *Is this a correction/change to a PREGNANCY OUTCOME FORM previously completed this school year? (Must complete and re-submit whole form in both cases)</p> <p>_____ Yes _____ No</p>	<p>8. Approximate number of prenatal care visits:</p> <p>_____ More than 17 visits _____ 1 to 4 visits</p> <p>_____ 11 to 17 visits _____ no prenatal care</p> <p>_____ 5 to 10 visits</p>
<p>2. *Student ID Number</p>	<p>9. Prenatal care setting:</p> <p>_____ Private medical doctor's office</p> <p>_____ Health care clinic</p> <p>_____ Other setting</p> <p>_____ No prenatal care</p> <p>_____ Unknown</p>
<p>3. Date form completed</p>	<p>10. Source of prenatal care payment</p> <p>_____ MediCal/Cal-Optima _____ Self pay/case</p> <p>_____ Private insurance _____ Other _____</p> <p>_____ Third-Party payer _____ No prenatal care</p> <p>_____ Unknown</p>
<p>4. *Agency Code:</p>	<p>11. Number of days MOTHER was hospitalized at delivery:</p> <p>_____ 0 days _____ 4 days</p> <p>_____ 1 day _____ 5 days</p> <p>_____ 2 days _____ more than 5 days</p> <p>_____ 3 days _____ Unknown</p>
<p>5. *Date of delivery or other outcome</p>	<p>12. Were there any complications during the pregnancy?</p> <p>_____ Yes _____ No</p> <p>* If yes, please specify:</p>
<p>6. Weeks of Gestation at Delivery:</p> <p>_____ More than 40 weeks _____ 35 weeks</p> <p>_____ 38-40 weeks (full term) _____ 34 weeks</p> <p>_____ 37 weeks _____ less than 34 weeks</p> <p>_____ 36 weeks</p>	
<p>7. Trimester Prenatal Care Began:</p> <p>_____ First trimester (1-13 weeks)</p> <p>_____ Second trimester (14-26 weeks)</p> <p>_____ Third trimester (27 weeks or later)</p> <p>_____ No prenatal care</p>	

<p>13. Were there any complications during the childbirth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:</p>	<p>19. Number of days child was hospitalized at delivery: <input type="checkbox"/> 0 days <input type="checkbox"/> 4 days <input type="checkbox"/> 1 day <input type="checkbox"/> 5 days <input type="checkbox"/> 2 days <input type="checkbox"/> More than 5 days <input type="checkbox"/> 3 days <input type="checkbox"/> Unknown</p>
<p>14. *Is this a repeat pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>20. Child Serious Medical Condition: <input type="checkbox"/> None <input type="checkbox"/> Suspected <input type="checkbox"/> Diagnosed, explain _____ <input type="checkbox"/> Unknown</p>
<p>15. *Pregnancy Outcome: <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death</p>	<p>21: Child Developmental Condition: <input type="checkbox"/> None <input type="checkbox"/> Suspected <input type="checkbox"/> Diagnosed, explain _____ <input type="checkbox"/> Unknown</p>
<p>COMPLETE REMAINING QUESTIONS FOR "LIVE BIRTH" PREGNANCY OUTCOMES ONLY.</p>	
<p>16. *Child's ID _____ Use parent's ID number with "01" for 1st child, "02" for 2nd child, etc.</p>	<p>22. Plan to use Cal-SAFE childcare: <input type="checkbox"/> Yes (Complete Cal-SAFE Childcare Enrollment Form) <input type="checkbox"/> Maybe (Complete Cal-SAFE Childcare Enrollment Form) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>17. Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>18. *Child's birth weight <input type="checkbox"/> Normal (more than 2,500 grams or 5 lbs 8 oz) <input type="checkbox"/> Low Birth Weight (less than 2,500 grams or 5 lbs 8 oz) <input type="checkbox"/> Unknown</p>	

Please review all questions for accuracy and make changes as needed, then turn this form in to the Cal-SAFE Office. Thank you.