



BABY SAFE HAVEN LAW MEDICAL HISTORY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

COMMUNITY ENGAGEMENT

SFN 61940 (9-2026)

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Thank you for bringing this infant to a Baby Safe Haven. You have taken the first step in assuring that the infant will be safe and well cared for. We know this has been a difficult decision and want to assure you that we will do everything we can to give this infant the best possible care.

We are asking you to **voluntarily** provide information that may be important to the infant's future. This information will be used only for this purpose. It will not be used to identify or to find you.

You may not know all the answers. Please provide as much information as you can.

Infant's Date of Birth	☐ Unsure
Infant's First and Middle Name on the Birth Certificate	
Infant's City and State of Birth	
Was the infant born in a hospital?	☐ Yes ☐ No ☐ Unsure
Was the infant born premature, before 38 weeks?	☐ Yes ☐ No ☐ Unsure
Were there any problems with the pregnancy or delivery?	☐ Yes ☐ No ☐ Unsure
If yes, describe the pregnancy or delivery problems:	
Does the infant require special formula or diet?	☐ Yes ☐ No ☐ Unsure
If yes, describe the special formula or diet:	
Before the infant was born, did the birth parent receive prenatal care?	☐ Yes ☐ No ☐ Unsure
Before the infant was born, did the birth parent take any medications, smoke, drink alcohol, or use any other drugs?	☐ Yes ☐ No ☐ Unsure
If yes, describe the medications, tobacco, alcohol, or other drugs used:	
Birth Parent's Race	☐ Unsure
Other Parent's Race	☐ Unsure
Is the birth parent Native American Indian?	☐ Yes ☐ No ☐ Unsure
If yes, enter the Tribe name:	
Is the other parent Native American Indian?	☐ Yes ☐ No ☐ Unsure
If yes, enter the Tribe name:	

If you are the birth parent, please read the symptoms below. If you answer yes to any of the questions, you may be having a medical concern and you should call or see a healthcare provider immediately. If you do not have a healthcare provider, seek care at an emergency room or call the Safe Haven hotline at 1-888-510-2229 or text 313131. Tell them that you are in the Safe Haven Program and need help.

Is your vaginal bleeding increasing and not slowing down when you rest?	☐ Yes	☐ No
Is your vaginal bleeding soaking through two maxi pads in a half-hour or are you passing large blood clots?	☐ Yes	☐ No
Does your vaginal bleeding or discharge have a bad smell?	☐ Yes	☐ No
Is your temperature 101 degrees F or higher?	☐ Yes	☐ No
Do you have abdominal pain that is not relieved by Tylenol or Motrin?	☐ Yes	☐ No
Are you urinating often? or Do you feel a burning sensation?	☐ Yes	☐ No
Is your pain increasing?	☐ Yes	☐ No

After the form is completed and returned to the approved location, it must be returned to North Dakota Department of Human Services:

Fax: 701.328.3538

Email: DHSCFS@nd.gov

Mail to: North Dakota Department of Human Services
Children and Family Services Division
600 E. Boulevard Ave - Dept 325
Bismarck, ND 58505-0250