Birth Plan

Mother's Name:_____
Father's Name:_____
Baby's Name:_____
Due Date:_____
Doula's Name:_____
Doctor/Midwife:_____
Pediatrician:_____

Walking during labor?

Yes / No

Lighting?

Dimmed / On

Use of a camera?

Yes / No

Use of an IV?

Yes / Hep Lock / No

Use of monitors:

Yes / If needed / No

Guests in the delivery room?

No / Yes, to include:

_____
_____
_____

Bottle/breastfeeding?

Use of Pain Medication:

None / IV only / Epidural

Cord – cutting, clamping, blood banking?

Cut by:_____

Delayed Clamping? Yes / No

Cord Blood Bank? Yes / No

Antibiotic eye ointment?

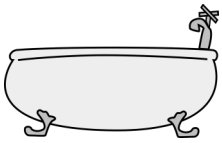
Yes / No

Vitamin K shot?

Yes / Delayed / No

First Bath?

Yes / Delayed



Circumcision?

Yes / No

Keep Placenta?

Yes / No

Hepatitis vaccine?

Yes / No

Pacifier?

Yes / No