STATE OF VERMONT

SUPERIOR COURT **PROBATE DIVISION**

Unit **Docket No.**

In re Adoption of :

INFORMATION ABOUT BIRTH FAMILY

Each Birth Parent should complete a separate form.

Today's Date: _____

Name of person completing form: _____

If not parent, relationship to parent: _____

Child's Full Name: _____

Date of Birth: _____ Time of Birth: _____

Place of Birth *(town, state, country)*: _____

BIRTH PARENT BACKGROUND

Parent's Full Name *(first, middle, last)*: _____

Maiden or previous name(s), if applicable: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____ Driver's License Number: _____ State: _____

Race: _____ Ethnic Background: _____

If you attend religious services, what kind? _____

Physical Address

_____

_____

_____

Mailing Address

_____

_____

_____

Please provide the name and address of a person who is likely to know where you are if you move:

_____

_____

_____

PHYSICAL DESCRIPTION

Height: _____ Weight: _____ Complexion: _____

Hair Color: _____ Eye Color: _____ General Build: _____

PERSONAL BACKGROUND

Where did you grow up? _____

What is the highest grade you have completed? _____ How did you do in school? _____

What were your favorite subjects? _____

If you had learning problems in school, what were they? _____

_____

If you have had other training, what kind? _____

What kind of jobs have you had? _____

Present occupation: _____

Briefly describe your personality:

_____

_____

_____

What are your interests and talents? *(examples of talents: artistic, mechanical, athletic, like science, musical, etc.)*

_____

_____

_____

Have you been in the military? ☐ Yes ☐ No

If Yes, what branch? _____

What was your rank and serial number? _____

What are your plans for the future?

_____

_____

_____

_____

_____

BIRTH PARENT'S FAMILY

Your **mother's** name *(first, middle, maiden)*: _____

Height: _____ Weight: _____ Age: _____ Race: _____

Hair Color: _____ Eye Color: _____ General Build: _____

General Health: _____

Level of Education: _____ Occupation: _____

Is she aware of the birth of this child? ☐ Yes ☐ No

If deceased, age and cause of death: _____

BIRTH PARENT'S FAMILY *(continued)*

Your **father's** name*)*: _____

Height: _____ Weight: _____ Age: _____ Race: _____

Hair Color: _____ Eye Color: _____ General Build: _____

General Health: _____

Level of Education: _____ Occupation: _____

Is he aware of the birth of this child? ☐ Yes ☐ No

If deceased, age and cause of death: _____

BROTHERS AND SISTERS

Full Name	Male / Female	Date of Birth	Last Grade Completed	Occupation
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			

MARRIAGES

Name of Spouse	Year Married	Year Divorced

BROTHERS AND SISTERS OF YOUR CHILD *(Include brothers and sisters living at home or elsewhere including children who were adopted, step-brothers and sisters and any children who may have lived in the child's home for an extended period of time.)*

Full Name	Male / Female	Date of Birth	Relationship to Child	Who is Caring for this Child?
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			

Does your child have a relationship with these brothers and sisters? Please describe.

_____
_____
_____
_____
_____
_____

PREGNANCY *(for birthmothers only)*

In what month did you begin pre-natal care? _____

Did you drink alcohol during this pregnancy? When during your pregnancy? How much at one time and how often?

_____
_____

What prescription drugs, over-the-counter medications or street drugs did you take during your pregnancy? What kind, how often, and when during the pregnancy?

_____
_____

Did you smoke? If so, how much? _____

Did you have any special problems during pregnancy? (for example: high blood pressure, diabetes, excessive bleeding, kidney or bladder infections, German or Three Day Measles, operations, convulsions, x-rays, sexually transmitted diseases or others):_____

At what age did you get your period? _____

YOUR CHILD'S HISTORY

Where was your child born? _____

Was this child born earlier or later than expected? ☐ Earlier ☐ Later

If so, how much earlier or later? _____ How long was your labor?_____

If drugs were used during your labor, what kind? _____

Were forceps used? ☐ Yes ☐ No

If you had a Caesarian Section (C-section), why? _____

If your child had any problems during the labor or soon after birth, please describe:

_____
_____
_____

What was your child's birth weight? _____ Birth length: _____

Did your child have special problems at birth? Please describe:

_____
_____

What is the name and address of your child's doctor?

_____

FOR CHILDREN WHO ARE NOT NEWBORNS

Who has your child's immunization records? _____

What illnesses has your child had?

- ☐ Chicken Pox
- ☐ Ear infections
- ☐ Frequent nausea or vomiting
- ☐ Frequent diarrhea or constipation
- ☐ Seizures or convulsions
- ☐ Rash/Skin problems
- ☐ Broken bones
- ☐ Pneumonia
- ☐ Trouble urinating
- ☐ Major operations, illnesses or accidents
- ☐ Bladder or Kidney Infection
- ☐ Whooping Cough
- ☐ Meningitis Red
- ☐ Sore throat
- ☐ Headaches
- ☐ Asthma
- ☐ Fainting
- ☐ Frequent swollen glands
- ☐ Frequent bruises or bleeding
- ☐ Mumps
- ☐ Hepatitis
- ☐ Measles
- ☐ Allergies
- ☐ Dizziness
- ☐ Hay Fever
- ☐ Dental cavities
- ☐ Rheumatic Fever
- ☐ Hospitalizations
- ☐ Anemia

If you checked any of the above, please describe:

_____

_____

_____

_____

_____

If your child has special educational needs, what are they?

_____

_____

If your child has been formally evaluated for any special problems, what was the evaluation for?

- ☐ Medical problem
- ☐ Learning/school problems
- ☐ Other: what kind? _____
- ☐ Dental or orthodontic
- ☐ Emotional disturbance or mental illness

If so, you may be asked to sign releases so that copies of the evaluations can be obtained.

Has your child been abused or neglected in the past?

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional or verbal abuse
- ☐ Neglect

If so, you may be asked to provide more information about the abuse or neglect.

If your child has ever lived with relatives, foster parents or other place away from home, please describe:

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Instructions:

If you have any of the problems listed below, or have had any problem in the past, please place a check in the box. If another family member has had the problem, place a check in the box and then list that person's relationship to you (examples: aunt, brother, grandmother). If you have more information about the particular problem, please provide it at the end of this section.

Acne or pimples	☐ Myself	☐ Other family member: _____
HIV infection or AIDS	☐ Myself	☐ Other family member: _____
Alcohol Abuse	☐ Myself	☐ Other family member: _____
Allergy to Food	☐ Myself	☐ Other family member: _____
What kind? _____		
Allergy to Other Things	☐ Myself	☐ Other family member: _____
What kind? _____		
Alzheimer's	☐ Myself	☐ Other family member: _____
Anemia	☐ Myself	☐ Other family member: _____
Anencephaly *(born with no brain)*	☐ Myself	☐ Other family member: _____
Arthritis	☐ Myself	☐ Other family member: _____
Where? _____		
Bedwetting	☐ Myself	☐ Other family member: _____
Bipolar illness *(manic depression)*	☐ Myself	☐ Other family member: _____
Birth defects	☐ Myself	☐ Other family member: _____
What kind? _____		
Blindness or very poor sight	☐ Myself	☐ Other family member: _____
Braces on teeth	☐ Myself	☐ Other family member: _____
Breast cancer	☐ Myself	☐ Other family member: _____
Bronchitis	☐ Myself	☐ Other family member: _____
Hodgkin's Disease	☐ Myself	☐ Other family member: _____
Cancer	☐ Myself	☐ Other family member: _____
What kind? _____		
Chlamydia	☐ Myself	☐ Other family member: _____
Cleft lip or palate	☐ Myself	☐ Other family member: _____
Club foot	☐ Myself	☐ Other family member: _____

Colitis	☐ Myself	☐ Other family member: _____
Color blindness	☐ Myself	☐ Other family member: _____
Cystic Fibrosis	☐ Myself	☐ Other family member: _____
Dental Problems	☐ Myself	☐ Other family member: _____
What kind? _____		
Deafness/hearing problems	☐ Myself	☐ Other family member: _____
Diabetes in childhood	☐ Myself	☐ Other family member: _____
Diabetes adulthood onset	☐ Myself	☐ Other family member: _____
Down's Syndrome	☐ Myself	☐ Other family member: _____
Drug Abuse	☐ Myself	☐ Other family member: _____
Dwarfism/very short height	☐ Myself	☐ Other family member: _____
Ear infections	☐ Myself	☐ Other family member: _____
Eczema	☐ Myself	☐ Other family member: _____
Emphysema	☐ Myself	☐ Other family member: _____
Epilepsy or seizures	☐ Myself	☐ Other family member: _____
Eye problems	☐ Myself	☐ Other family member: _____
Genital Warts	☐ Myself	☐ Other family member: _____
Very tall height	☐ Myself	☐ Other family member: _____
Glasses	☐ Myself	☐ Other family member: _____
What kind? _____		
Glaucoma	☐ Myself	☐ Other family member: _____
Gynecological Problems *(female)*	☐ Myself	☐ Other family member: _____
What kind? _____		
Gonorrhea	☐ Myself	☐ Other family member: _____
Headaches or migraines	☐ Myself	☐ Other family member: _____
Heart attack/heart problems	☐ Myself	☐ Other family member: _____
Hemochromatosis	☐ Myself	☐ Other family member: _____
Hemophilia or bleeding	☐ Myself	☐ Other family member: _____
Hepatitis	☐ Myself	☐ Other family member: _____
Herpes	☐ Myself	☐ Other family member: _____

Hives	☐ Myself	☐ Other family member: _____
High blood pressure	☐ Myself	☐ Other family member: _____
Huntington's Chorea	☐ Myself	☐ Other family member: _____
Infertility/difficulty getting pregnant	☐ Myself	☐ Other family member: _____
Jaundice or yellow skin	☐ Myself	☐ Other family member: _____
Kidney disease	☐ Myself	☐ Other family member: _____
Learning problems or disabilities	☐ Myself	☐ Other family member: _____
Left handed	☐ Myself	☐ Other family member: _____
Liver disease	☐ Myself	☐ Other family member: _____
Lung problem	☐ Myself	☐ Other family member: _____
Lupus	☐ Myself	☐ Other family member: _____
Mental illness	☐ Myself	☐ Other family member: _____
What kind? _____		
Miscarriages	☐ Myself	☐ Other family member: _____
Muscular Dystrophy	☐ Myself	☐ Other family member: _____
Obesity/significant overweight	☐ Myself	☐ Other family member: _____
Osteoporosis	☐ Myself	☐ Other family member: _____
Paralysis	☐ Myself	☐ Other family member: _____
Phenylketonuria (PKU)	☐ Myself	☐ Other family member: _____
Rectal or intestinal polyps	☐ Myself	☐ Other family member: _____
Rheumatic fever	☐ Myself	☐ Other family member: _____
Schizophrenia	☐ Myself	☐ Other family member: _____
Serious depression	☐ Myself	☐ Other family member: _____
Sickle cell anemia	☐ Myself	☐ Other family member: _____
Skin disease	☐ Myself	☐ Other family member: _____
Spina bifida	☐ Myself	☐ Other family member: _____
Speech problems	☐ Myself	☐ Other family member: _____
What kind? _____		

Still births	☐ Myself	☐ Other family member: _____
Stomach problems	☐ Myself	☐ Other family member: _____
What kind? _____		
Strokes	☐ Myself	☐ Other family member: _____
Suicide/suicide attempt	☐ Myself	☐ Other family member: _____
Surgery	☐ Myself	☐ Other family member: _____
What kind? _____		
Syphilis	☐ Myself	☐ Other family member: _____
Sachs Disease	☐ Myself	☐ Other family member: _____
Thalassemia	☐ Myself	☐ Other family member: _____
Thyroid problems	☐ Myself	☐ Other family member: _____
Twins or multiple births	☐ Myself	☐ Other family member: _____
Ulcers	☐ Myself	☐ Other family member: _____
Varicose veins	☐ Myself	☐ Other family member: _____
Wilson's Disease	☐ Myself	☐ Other family member: _____

Other: _____

Have you ever had a formal evaluation for medical, mental health or educational reasons?

☐ Yes ☐ No

Please explain:

_____

_____

_____

ADOPTION PLANS FOR YOUR CHILD

What led to your decision to plan adoption for your child?

_____

_____

_____

_____

_____

_____

_____