Biological Parent's Introductory Information

(Please print using blue or black ink)

The information requested in the following pages is necessary to help in finding the best adoptive family for you. Please take your time and complete this form. If you would prefer, you may have our agency social worker complete this form during an interview with you instead of on your own. The end of this document is a release of information that must be completed for Adoption Makes Family to move forward with your adoption plan..

How did you hear about our agency?

Verizon Yellow Pages □ City Paper □ Penny Saver □ MTA Bus □
Community Yellow Pages □ Clinic □ Which Clinic ____
Hospital Social Worker □ Which Hospital? _____

Today's Date:	Due Date: or weeks along
Full Name (First, Middle, Last & Maiden)	Maiden
Current Address (No PO Boxes)	
City, State, Zip code	
County	
Social Security Number	
Home Telephone Cell Telephone Work Telephone	May we contact you at: Leave indentifying at: Home? Yes □ No □ Home: Yes □ No □ Cell? Yes □ No □ Cell? Yes □ No □ Work? Yes □ No □ Work? Yes □ No □
Living Arrangements	With whom do you live? _____ Are they aware of your pregnancy? Yes □ No □ Are they aware you are considering adoption? Yes □ No □ If yes, are they supportive of your adoption plan? Yes □ No □ Do your parents know of your adoption plans? Yes □ No □ Do your parents agree with your adoption plans? Yes □ No Do your friends know of your adoption plans? Yes □ No □ Do your friends agree with your adoption plans? Yes □ No
Email	
Birth Date/Place of Birth	
Your Race	□Caucasian □ African American □ Hispanic □ Asian □ Other _____(Check all that apply)
Marital Status	□ Single □ Married □ Separated □ Divorced □ Other
United States Citizen	□ Yes □ No. If no, passport/visa #

What will be your age when you when you child is born? _____
What is your height _____?
What was your weight before your pregnancy? _____

Your Schooling

Number of years Attended:
___ Grade School ____ High School ___ College ___ Other _____

Educational Achievements: _____

Educational Goals _____

Hobbies/Interests: _____

Favorite Foods: _____

On the scale below, please indicate how committed you are to creating this adoption plan.

1 2 3 4 5 6 7 8 9 10

Totally not committed Very Committed.

ADOPTIVE FAMILY INFORMATION

The information below will give us a basic idea of the qualities in the adoptive family you are looking for. You and your social worker will talk more about this when you meet and develop a more specific profile to meet your wishes.

Marital Status of the adoptive family:

Married Single Same Sex Couples No Preference

Preferred Race of the adoptive family _____
Preferred Religion of the adoptive family_____

Have you considered other options including a family member or friend to adopt?	Yes □	No □
Has any family member or friend expressed an interest in adopting your child?	Yes □	No □
Has any of the birth father's family or friends expressed an interest in adopting?	Yes □	No □
Are you open to a family that smokes cigarettes?	Yes □	No □
Are you open to a family who has other children	Yes □	No □
Do you want to be involved in selecting the adoptive family?	Yes □	No □
Do you want to meet the adoptive family?	Yes □	No □
Do you want the adoptive family present for the birth?	Yes □	No □
After the birth do you want contact with the adoptive family?	Yes □	No □

Please circle: Letters Pictures Personal visits No Contact

During the pregnancy, how much contact do you want with the adoptive family?

Please circle: Phone calls? Personal visits? Contact only through the social worker?

Please explain what has lead you to choose an adoption plan. _____
_____
_____
_____

ADDITIONAL BACKGROUND INFORMATION

The following information will not interfere or in any way influence the adoption process. It is solely information that is often asked by adoptive families.

Were you adopted?	Yes □ No □ If yes, what information do you know?
Have you ever placed a child for adoption before?	Yes □ No □ If yes, please describe in detail.
Have you ever been arrested or convicted?	Yes □ No □ If yes, please give information.
Have you ever been reported for child abuse or neglect?	Yes □ No □

Not everyone who thinks they are an American Indian is an American Indian under the law. The law applies to federally recognized Indian Tribes and only applies if enrollment or the possibility of enrollment exists. Whether or not someone is enrolled is usually shown by the person having a Certificate of Degree of Indian Blood (CDIB) card issued by the Bureau of Indian Affairs. Another indicator of enrollment is someone in the family being able to use an "Indian Hospital."

Are you a member of a Native American or Alaskan Native Tribe?	Yes □ No □ If yes,, please list Tribe(s)
Are you eligible for membership to the Tribe?	Yes □ No □
Are any of your relatives a member of a Tribe?	Yes □ No □
If you answered yes to any of these questions, please indicate the location, your registration or identification number, and all family members with tribal affiliation.	

BIOLOGICAL MOTHER'S FAMILY INFORMATION

This information will not be used to contact anyone. It is for background information only

Your Mother's Name		□ Caucasian □ African-American □ Hispanic □ Asian □ Other ___
Your Father's Name		□ Caucasian □ African-American □ Hispanic □ Asian □ Other ___
Your Brother/Sister's Name		□ Caucasian □ African-American □ Hispanic □ Asian □ Other ___
Your Brother/Sister's Name		□ Caucasian □ African-American □ Hispanic □ Asian □ Other ___

Please list any additional siblings on the back of this form

CURRENT PREGNANCY INFORMATION

Is this your first pregnancy?	Yes □ No □ If no, how many prior pregnancies?
Please indicate what occurred with your prior pregnancies	Carried to term _____ Abortion _____ Miscarriage _____ Vaginal birth ____ C-Section ___
Have you been involved in any accidents during this pregnancy?	Yes □ No □ If yes, please explain in detail:
Have there been any complications during this pregnancy? Did you have any complications in previous pregnancies?	Yes □ No □ If yes, please explain in detail: Yes □ No □ If yes, please explain in detail
Have you been exposed to any of the flowing during your pregnancy? (Please check all that apply)	□ X-ray □ EKG □ Radiation □ None

HISTORY OF PREVIOUS CHILDREN

NAME	DATE OF BIRTH	GENDER	BIRTH WEIGHT	RACE	½ OR FULL SIBLING TO BABY	LENGTH OF PREGNANCY
		□ M □ F			□ Half □ Full	□ Full Term □ Overdue □ Premature
		□ M □ F			□ Half □ Full	□ Full Term □ Overdue □ Premature
		□ M □ F			□ Half □ Full	□ Full Term □ Overdue □ Premature

BIRTH FATHER INFORMATION

Your adoption social worker will speak with you in further detail about your information regarding the birth father. If he wants to be involved in your adoption plan, the adoption social worker can send him social and medical history forms to complete

What is the name of the birth father?	
What is his date of birth and/or age?	
What is the phone number of the birth father	
In what city and state did you conceive?	
What was the approximate date of the conception?	
Are you certain the identified birthfather is the biological father? Has the identified birth father acknowledged that he is the biological father?	Yes □ No □ Yes □ No □
What is the race of the birth father?	Caucasian African American □ Hispanic Asian □ Other _____(Check all that apply)
What was the date when you last saw the birth father?	
What were the circumstances of your last contact with the birth father	
Have you lived with the birth father before or during your pregnancy? Do you live together now?	Yes □ No □ Yes □ No □
How and where did you meet the birth father?	
Do you think he will sign papers to place the child for adoption?	Yes □ No □ Unknown □ If no or unknown, please explain.
Has he given or offered any support financially or emotionally during this pregnancy?	Yes □ No □ If yes, please explain:
Do the parents of the birth father know of the adoption plans? Do the parents of the birth father agree with the adoption plans?	Yes □ No □ Yes □ No □

PRENATAL CARE AND HOSITAL INFORMATION

Please attach a copy of your current Medicaid or insurance card and a copy of your driver's license or identification card.

Have you received prenatal care? Yes □ No □ If yes, what month of your pregnancy did you start receiving care? _____ Does your Doctor/Clinic know of your adoption plans? Yes □ No □	From what doctor/clinic have you received prenatal care? Name: _____ Address: _____ _____ Phone _____ Fax _____
MEDICAID INFORMATION: Do you have state issued Medicaid? Yes □ No □ If yes, Medicaid # _____ Medicaid worker's name and phone # _____ In what state was Medicaid Issued _____ If you do not have Medicaid, are you willing to apply? Yes □ No □	What is the name of the hospital where you will be delivering or midwife assisting you? Name: _____ Address: _____ _____ Phone: _____ Fax: _____ □ I don't know this information yet
INSURANCE INFORMATION Private medical insurance Yes □ No □ If yes, what carrier? (i.e. United Healthcare, Blue Cross Blue Shield, etc) Name: _____ Address: _____ Phone w/area code: _____ Policy Number _____ Percentage of bills covered? _____	Do you have a State issued driver's license of ID card? Yes □ No □ Is yes, what is the #? _____ State driver's license or ID issued in? _____

PLEASE INDICATE THE AMOUNT OF YOUR MONTHLY EXPENSES:

Rent $_____
Groceries $_____
Automobile $_____
Medications $_____
Clothing $_____

HEALTH HISTORY OF BIOLOGICAL MOTHER

Place an "X" if the listed medical condition exists in your medical history or if any other family members have/had any of the conditions. Please also indicate if the birth father and/or his family has any of these conditions. If a condition resulted in death of a family member, please indicate "deceased" next to their name if the Other Family Member(s) section. On the bottom of each page of health history, there is a section where you can explain self or other family member(s) medical history. Please explain in detail (i.e. Bipolar, prescribed Lithium since age 13). Please fill out accurately as possible. We have wonderful, loving families willing to accept children that have any medical conditions.

Infections Diseases: □ Nothing applies to me in this section.

	Self	Other Family Member(s) If applicable, who?
HIV/AIDS		
Sexually Transmitted Diseases STD		
Hepatitis A B C (Please circle if applicable)		
Other		

Oncology: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Cancer (Please list type)		

Congenital: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Mental/Physical Retardation		
Down's Syndrome		
Spina Bifida		
Congenital Heart Defect		
Sudden Infant Death Syndrome SIDS		
Other		

If you selected any box from above, please explain in further detail below

Medical Condition	Age of onset	Medication/Treatment	Other explanation

Women's Health: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Problematic Pregnancies		
Menstrual Irregularities		
Endometriosis		
Ovarian Cysts		
Other		

Eyes/Ears/Nose/Throat: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Blindness (Specify Cause)		
Glaucoma		
Other Visual Problems		
Deafness (specify cause)		
Other Ear Problems		

Cardiovascular: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Hypertension (High Blood Pressure)		
Low Blood Pressure		
Heart Murmurs		
Heart Attack(s)		
Stroke		
High Cholesterol		
Congestive Heart Failure		
Other		

Hematological: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Anemia		
Hemophilia		
Other		

If you selected any box from above, please explain in further detail below

Medical Condition	Age of onset	Medication/Treatment	Other explanation

Respiratory Problems: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Asthma		
Bronchitis/Emphysema		
Frequent Pneumonia		
Other		

Gastrointestinal: □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Ulcers		
Colitis		
Gall Bladder Problems		
Irritable Bowel Syndrome (IBS)		
Other		

Genitourinary □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Bladder Problems		
Kidney Problems		
Urinary Track Infections		
Other		

Neurological □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Alzheimer's		
Epilepsy		
Seizures		
Multiple Sclerosis (MS)		
Cystic Fibrosis		
Other		

If you selected any box from above, please explain in further detail below

Medical Condition	Age of onset	Medication/Treatment	Other explanation

Behavioral □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Learning Disability		
ADHD/ADD		
Alcoholism or Heavy Drinking		
Drug Abuse		
Bulimia/Anorexia Nervosa		
Other		

Mental Health □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Schizophrenia		
Bipolar Disorder		
Depression (diagnosed)		
Other		

Miscellaneous □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?
Eczema		
Arthritis		
Diabetes 1		
Diabetes 2		
Hypoglycemia		
Other		

If you selected any box from above, please explain in further detail below.

Medical Condition	Age of onset	Medication/Treatment	Other explanation

Allergies □ Nothing applies to me in this section

Allergic To?	Reaction? (rash/hives, tc)	Self	Other family members

Past Surgeries/Procedures □ Nothing applies to me in this section

	Self	Other Family Member(s) If applicable, who?

Medications/Prescription Drugs

Name	Prescribed for?	Length of use

Please list any other medical issues that were not covered in the questions above:

_____

_____

CONFIDENTIAL DRUG/ALCOHOL USAGE

Please be very specific and honest as to any drugs or alcohol used during your pregnancy and the frequency of use. This information is very important. We have many wonderful families open to adopting your baby no matter what substance you have used. Please place an "X" only in the boxes applicable to your usage.

Substance	Used occasionally (1 to 5 times) during pregnancy	Used daily during pregnancy	Used weekly during pregnancy	Used monthly during pregnancy
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Methamphetamines				
Heroin				
Ecstasy				
Methadone				
LSD				
Anti-Depressants				
Diet Pills				
Tranquilizers				
Anti-Convulsants				
Other				
Other				

I understand the information I have supplied in the Biological Parent Social and Medical History is true and accurate. I also understand that the adoptive family and other parties will relay on this information to decide whether or not to move forward why any anticipated adoption plans. Furthermore, the Court will rely on this information during the adoption related proceedings. I hereby waive any claim of privilege and agree that the information contained on this form and any information provided by myself, my counselors, and my physicians may be given to the adoptive parent's agency, their attorney, other attorneys, and

other state officials, including law enforcement authorities, through all communication mediums. I also understand that the information I have provided will be shared with the adoptive parents in a confidential manner without disclosing identifying information and to the medical professionals at the medical facility where my prenatal care and my delivery will take place.

I understand that Maryland law prohibits a birth mother from receiving compensation for creating and/or finalizing an adoption plan.

I further understand that I am entering into a program that places children for adoption and any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties. I also understand that working simultaneously with more than one attorney, agency, or adoptive family may subject me to criminal and/or civil penalties under the law.

In my written and verbal communication in connection with my adoption plan, I have not provided any false or misleading information of any kind, to include information concerning myself, the biological father, or the background or medical history of my family.

Under penalties of perjury, I declare that I have read the foregoing and the facts stated in the documents are true.

Please sign and date on the line below.

_____ _____

Signature Date

INFORMATION FOR PARENTS CONSIDERING CREATING AN ADOPTION PLAN

Sometimes parents are faced with situations that require them to consider making an adoption plan for their child. Adoption Makes Family is prepared to help you reach a decision that will be in the best interest of your child and your family. The following information is provided to you to explain your rights before, during and after the process: The types of adoptions and the process used to select an adoptive family.

FACTS ABOUT SIGNING A CONSENT FOR ADOPTION AND CREATING ADOPTION PLAN

1. Each state has its own laws relating to when you can sign papers allowing an adoption.

2. You cannot sign anything allowing a child to be adopted before the child is born.

3. In Maryland, you may sign the consent at the time the child is born.

4. In Maryland, there is a 30 day revocation period whereby a birth parent may change their mind about the adoption plan and cancel the adoption plan 30 days expires.

5. In every state, once you sign an adoption consent and the revocation period goes by, if you change your mind, you will no longer have any rights to the child. It is extremely important that you talk with an attorney and or the social worker about the legal procedure in your state. You have the right to fully understand the adoption process. The attorney who represents Adoption Makes Family, Inc. does not represent you.

TYPES OF ADOPTION

The type of adoption plans that is developed for your child is based on what is in your child's best interest. The staff at Adoption Makes Family will help you design an adoption with which you are comfortable. The relationship that you develop with your child's adoptive family will be unique and change over time. Adoption Makes Family is committed to help negotiate this relationship and the amount of contact you have with the adoptive family. In some cases, such as in the adoptive placement of an older child, or when the child and the adoptive parents are related, an open adoption placement is made. By open adoption placement, we mean the identities of the adoptive couple and the birth parents are exchanged and the post-placement direct contact may occur between the birth parents and the adoptive parents that legally cannot be enforced by Adoption Makes Family. Even though there may be some degree of openness, because of this agreement, the adoptive parents still hold full parental rights and responsibilities for the child. Adoption Makes Family places most children with families who reside in Maryland. However, there are cases where a child may be placed with a family from another state.

_____ _____

Signature Date

Adoption Makes Family will act as an Intermediary between you and the adoptive couple and your child if you wish to send your child any written information, provide your child with photos or with gifts or mementos. All adoptive couples have a social service and police clearance to make sure there is no known history of criminal activity, alcohol or abuse.

FACTS ABOUT SELECTING ADOPTIVE PARENTS

In selecting an adoptive family for your child, consideration will be given to members of your extended family first. If adoption by a relative is not feasible, Adoption Makes Family has the following procedures for selecting an adoptive family.

You may request that your child be placed with an adoptive family of your same religious and/or ethnic background, i.e. racial. Adoption Makes Family will try to honor your request.

All adoptive families must complete a special training program that develops their understanding of how to best meet children's needs. This includes information about child development, explaining adoption to children, and baby care.

Adoption Makes Family checks on the applicants and members of their household to determine if they have criminal records that would make them unsuitable to raise children.

Adoption Makes Family receives references regarding all applicants to determine if their friends, employers and relatives consider them to be suitable to be adoptive parents.

A social worker from Adoption Makes Family meets with the applicants and goes to their home to determine if they can provide a safe, loving and good family life for a child.

Applicants must obtain a statement from a physician confirming they have no physical and/or mental health problems that would interfere with raising a child.

You may request that your child be placed with a particular family for adoption. This is called a "designated adoption." However, the decision for placement will be the responsibility of Adoption Makes Family. In the unlikely event that the family you select for your child is unable, for unforeseen reasons, to receive placement of the child, Adoption Makes Family will use its sole discretion in selecting a family.

If a specific family has been selected for your child, you may request that you be provided with certain information. This will be non-identifying and why it is believed this family will meet your child's needs.

_____ _____

Signature Date

Authorization for Release of Medical Information

I hereby request and authorize: Adoption Makes Family, Inc
10635 York Road
Cockeysville, MD 21030
Phone 410-683-2100 Fax 410-666-7880

To obtain from:

Hospital (name and address): _____
_____

Doctor (name and address): _____
_____

Requesting Medical Records from _____ to _____

____ All medical information reports
____ HIV test results
____ X-ray reports
____ Physical examination reports
____ Psychological testing
____ Other (specify): any and all other medical reports or records.

____ Immunization records
____ Prenatal records
____ Alcohol and Drug screening
____ Medical Data for WIC Certification
____ Laboratory Reports

Except for the following, which may not be disclosed (if none, write none): NONE

From the medical record of: _____
(name of client, date of birth and social security number)

For the purpose of: _____ADOPTION_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my express written consent. I understand that this authorization will remain in effect for 1 (one) year unless I specify an earlier date here _____NONE_____.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that my confidential information may be released to the adoptive family in a non-identifying manner. I understand that I may withdraw this consent at any time as long as the request is made in writing to the above listed medical provider. However, I understand that if I revoke this authorization, it will not have an effect on action taken by the above medical provider in reliance on it before my revocation.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Signature of parent if client is under 18 years of age Date

Use this space only if client withdraws consent

_____ _____
Signature of Client Date of revocation

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL