ADOPTION INFORMATION/APPLICATION
FOR ADOPTION CHOICES OF OKLAHOMA

Application fee is $200.00 made out to Adoption Choices and must accompany application. This fee is non-refundable. (All information will remain confidential unless your permission is granted, in writing, to release part or parts of it.) Please remember that with the new age of technology and the internet, your name, address and phone can possibly be located through diligence by a birth parent or former adoptive parent.

☐ Second Placement Application Date: _____

First Applicant's full name: _____
Second Applicant's full name: _____
Home address: _____
Home telephone number: (____)_____
First Applicant's cell/mobile number: (____)_____
Second Applicant's cell/mobile number: (____)_____
Home fax number: (_____)_____
E-mail address: _____
Date and place of marriage: _____
Names and birth dates of children of this marriage. State whether adopted or biological.
_____
Who referred you to us? _____

PERSONAL INFORMATION

Please provide pictures in the blocks below:

Picture of yourselves	**Picture of your home**

FIRST APPLICANT: Age and date of birth: _____
Social Security No.: _____
Race/Nationality: _____
Weight & Height: _____
Education:_____
Occupation: _____
Employer: _____
How long? _____
Office address: _____
Office telephone: _____ Fax _____
Office e-mail: _____
Annual income: _____
Religious preference: _____
Dates of previous marriages and divorces: _____
Children: (ages and custody status) _____
_____

SECOND APPLICANT: Age and date of birth: _____
Social Security No.: _____
Race/Nationality: _____
Weight & Height: _____
Education: _____
Occupation: _____
Employer: _____
How long? _____
Office address: _____
Office telephone: _____
Fax _____
E-mail : _____
Annual income: _____
Religious preference: _____
Dates of previous marriages and divorces: _____
Children: (ages and custody status) _____
_____

FAMILY BACKGROUND

FIRST APPLICANT: Father's name: _____
Address: _____
Phone number: _____
Age and occupation: _____

Mother's name: _____
Address: _____
Phone number: _____
Age and occupation: _____

Brothers and/or sisters:
Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

SECOND APPLICANT: Father's name: _____
Address: _____
Phone number: _____
Age and occupation: _____

Mother's name: _____
Address: _____
Phone number: _____
Age and occupation: _____

Brothers and/or sisters: Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____

_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

Name: _____
Address: _____
Phone number: _____
Age and occupation: _____
Marital status and spouse's name: _____
Names and ages of children: _____
_____

MEDICAL PROBLEMS

Past or present
First Applicant: _____
_____
_____

Second Applicant: _____
_____
_____

REFERENCES

Please list three references who have written letters on your behalf. Please also enclose the letters. It is the policy of our agency to call these references to verify that the individual(s) actually wrote the letters.

Name: _____
Address: _____
Phone number: _____

Name: _____
Address: _____
Phone number: _____

Name: _____

Address: _____
Phone number: _____
Have you had an adoption fail or fall through? If so, briefly describe the circumstances.
_____
_____
_____
_____
_____
_____

Have you had a home study done by anyone for adoption purposes? If so, who did it and when? Please enclose a copy if you were given one. _____
_____
_____

Have you ever been denied a favorable home study? If so, when and for what reason?
_____
_____

What other methods are you using to try and adopt? _____
_____

How long have you been trying to adopt? _____
_____

Have either of you ever had psychiatric problems or problems with alcohol or drug abuse? Please explain. _____
_____
_____

Have you applied for a child elsewhere? If so, when and where? What were the results?
_____
_____
_____

INFORMATION ON CHILD YOU WISH TO ADOPT

Sex and age preference: _____
Would you accept twins? _____

Nationality you would accept:

Caucasian:	_____		
Hispanic:	_____	Hispanic mix:	_____
African American:	_____	African American mix:	_____
Asian/Oriental:	_____	Asian/Oriental mix	_____
Hawaiian	_____	Hawaiian mix	_____

Other: _____

Are either of you enrolled or eligible for enrollment in any Indian Tribe? What Tribe?
_____
_ _____

Would you accept:
An older child? _____ To what age? _____
More than one older child if siblings? _____
A child with a correctable medical condition? _____
A child with a non-correctable medical condition? _____

Openness in Your Adoption
Second placement adoptions occur when the original adoptive families believe it is in the child's best interest to find a new adoptive home. Many of the children in need of a second adoptive placement were adopted domestically out of foster care or internationally.

Adoption Choices of Oklahoma works closely with the original adoptive family to learn the child's unique needs. Each original adoptive family creates a personalized adoption plan with their preferences for adoptive parents, including openness. Adoptions are generally classified as Open, Semi-open, or Closed, but not everyone defines those terms in the same way.

Please indicate the scenarios that you would be comfortable with once a birth parent has chosen you:

___ The first adoptive parent(s) would be given your last name.
___ The first adoptive parent(s) would be given your phone number.
___ The first adoptive parent(s) would be given your address.
___ The first adoptive parent(s) would meet you in person.
___ The first adoptive parent(s) would have an annual visit with you and the child after placement.

Indicate your level of acceptance of a child who has the following problems:

		INDICATE YES	NO	MAYBE
DRUGS				
Would you accept a child whose biological mother:				
A.	Had used drugs before realizing she was pregnant?	☐	☐	☐
B.	Has continued to use drugs during her pregnancy?	☐	☐	☐
C.	Had used drugs in the past but not at or since the time of conception?	☐	☐	☐
D.	Whose biological father had used drugs at conception or was using drugs during the pregnancy?	☐	☐	☐
ALCOHOL				
Would you accept a child whose biological mother:				
A.	Had used alcohol before realizing she was pregnant?	☐	☐	☐
B.	Has continued to use alcohol during her pregnancy?	☐	☐	☐
C.	Had used alcohol in the past but not at or since the time of conception?	☐	☐	☐

CHILDREN

A.	Slight limp	☐	☐	☐
B.	Leg braces	☐	☐	☐
C.	Missing limb	☐	☐	☐
D.	Is in a wheel chair	☐	☐	☐
E.	Is paraplegic	☐	☐	☐
F.	Is quadriplegic	☐	☐	☐
G.	Cerebral Palsy	☐	☐	☐
H.	Cystic Fibrosis	☐	☐	☐
SEIZURES				
A.	Seizure disorder controlled by medication	☐	☐	☐
B.	Seizure disorder not controlled but has infrequent seizures	☐	☐	☐
C.	Seizure disorder not controlled and has frequent seizures	☐	☐	☐
BLOOD DISORDERS				
A.	Blood disorder requiring blood transfusions every 3 months	☐	☐	☐
B.	Blood disorder requiring hospitalization once a month	☐	☐	☐
C.	Blood disorder resulting in a limited lifespan	☐	☐	☐
HEART PROBLEMS				
A.	Heart murmur, activity not curtailed	☐	☐	☐
B.	Heart murmur, vigorous activity curtailed	☐	☐	☐
C.	May require open heart surgery at a later date but at placement needs only to be watched	☐	☐	☐
D.	Definitely will require open heart surgery	☐	☐	☐
E.	Will require more than one open heart surgery	☐	☐	☐
SIGHT PROBLEMS				
A.	Sight in both eyes but vision is limited/glasses needed	☐	☐	☐
B.	Sight in one eye only	☐	☐	☐
C.	Blind but surgery may give partial sight	☐	☐	☐
D.	Blind and will never have sight	☐	☐	☐
HEARING PROBLEMS				
A.	Hearing problem with only partial hearing/surgery may help	☐	☐	☐
B.	Hearing problem with partial hearing/surgery will not help	☐	☐	☐
C.	Hearing in only one ear	☐	☐	☐
D.	No hearing, deaf and does not speak	☐	☐	☐
PHYSICAL DEFORMITIES				
A.	Deformed hand	☐	☐	☐
B.	Deformed arm	☐	☐	☐
C.	Deformed leg	☐	☐	☐
D.	Deformed face	☐	☐	☐
E.	Two deformed arms	☐	☐	☐
F.	Two deformed legs	☐	☐	☐
SPECIAL NEEDS CHILDREN				
A.	In special education	☐	☐	☐
B.	In EMR	☐	☐	☐

C.	In TMR	☐	☐	☐
D.	Retarded and will always need supervision	☐	☐	☐
E.	Downs Syndrome	☐	☐	☐

HYPERACTIVE PROBLEMS (OLDER CHILDREN)

A.	Hyperactive	☐	☐	☐
B.	Hyperactive, requires medication/functions normally	☐	☐	☐
C.	Hyperactive, requires medication and some kind of special classroom setting	☐	☐	☐

EMOTIONAL PROBLEMS (OLDER CHILDREN)

A.	Emotionally damaged, very withdrawn and will require therapy for an extensive period of time	☐	☐	☐
B.	So emotionally damaged he/she is very abusive toward other people; a child who is abusive to animals	☐	☐	☐
C.	Emotionally damaged; he/she is very abusive toward his/her person (pulling hair, pinching self)	☐	☐	☐

SPEECH PROBLEMS (OLDER CHILDREN)

A.	Stutters	☐	☐	☐
B.	Lisp	☐	☐	☐
C.	Speech at age 6 is very hard to understand	☐	☐	☐
D.	Will always have trouble speaking and being understood	☐	☐	☐

CLEFT PROBLEMS (OLDER CHILDREN)

A.	Hare lip	☐	☐	☐
B.	Cleft palate	☐	☐	☐
C.	Both hare lip and cleft palate	☐	☐	☐

SICKLE CELL ANEMIA DISORDER (OLDER CHILDREN)

A.	Sickle Cell carrier	☐	☐	☐
B.	Sickle Cell Anemia but relatively controlled	☐	☐	☐
C.	Sickle Cell Anemia with frequent episodes	☐	☐	☐

BURNS (OLDER CHILDREN)

A.	Burn scars	☐	☐	☐
B.	Slight	☐	☐	☐
C.	Extensive, needing surgery	☐	☐	☐

BIRTH MARKINGS (OLDER CHILDREN)

A.	Birth marks	☐	☐	☐
B.	Small	☐	☐	☐
C.	Large or extensive	☐	☐	☐

BI-POLAR DISORDER

A.	Had one parent diagnosed with bi-polar disorder?	☐	☐	☐
B.	Had both parents diagnosed with bi-polar disorder?	☐	☐	☐
C.	Had grandparent(s) diagnosed with bi-polar disorder?	☐	☐	☐
D.	Had one parent who was taking medication during pregnancy for bi-polar?	☐	☐	☐

SCHIZOPHRENIA

A.	Schizophrenic child	☐	☐	☐
B.	Had one parent diagnosed as schizophrenic	☐	☐	☐
C.	Had two parents diagnosed as schizophrenic	☐	☐	☐
D.	Had grandparents diagnosed as schizophrenic?	☐	☐	☐

DEPRESSION

A.	Had one parent who was depressed but not on medication?	☐	☐	☐
B.	Had two parents who were depressed but not on medication?	☐	☐	☐
C.	Had one parent who was depressed and on medication?	☐	☐	☐

YOUR HOME

Do you own or rent your home? _____
If own, value of home: _____
Mortgage left on home: _____
Rent or house payment: _____

FINANCES

List your assets and liabilities on the Statement of Net Worth form attached.
Do you have health insurance? _____
Life insurance? How much? _____

GENERAL QUESTIONS

Why do you wish to adopt a child? _____
_____
_____
_____

Have you ever been arrested, or do you have any type of criminal record? If yes, please explain: _____
_____
_____
_____

Any other comments or information you would like to add: _____
_____
_____
_____
_____

We understand and acknowledge that our application fee of $200.00, which is non-refundable, guarantees our being on Adoption Choices' waiting couples list for second placement adoptions for a period of one year. We further understand that adoption costs vary from situation to situation, and that upon our being matched with an original adoptive family and/or child we will be responsible for paying the full estimated amount of that particular situation. We understand

that those funds will be placed in an escrow account and costs incurred by the agency on behalf of our birth mother will be paid from that account. We further understand that if the adoption fails, the agency placement fee, minus a $3,500.00 Agency Services fee, will be reimbursed to us. All other fees and costs are at risk.

SIGNATURES:

_____

First Applicant Date

_____

Second Applicant Date

MEDICAL STATEMENT

Medical Statement for Adoptive Applicant
And all Household Members for Domestic Adoption

Name (Last, First, Middle)	Date of Birth:
Address (Street, City, State & Zip):	

1. Have you had treatment for a serious or chronic illness: ☐ Yes ☐ No
   Have you been hospitalized in the past five years? ☐ Yes ☐ No
   Have you ever received, or been advised to seek, mental health services? ☐ Yes ☐ No
   Have you ever received, or been advised to seek, treatment for Alcohol/substance abuse? ☐ Yes ☐ No
   Have you ever had a communicable disease? ☐ Yes ☐ No

   If the answer to any of these questions is yes, please explain:
   _____
   _____

2. Do you have or have you had any of the following? (Check all that apply.)

☐	Arthritis _____	☐	Heart Disease _____
☐	Asthma _____	☐	Hypertension _____
☐	Cancer _____	☐	Kidney Disease _____
☐	Epilepsy _____	☐	Tuberculosis _____
☐	Diabetes _____	☐	Ulcers _____

   If any are checked, please explain: _____
   _____

3. Is there a history of other hereditary disease? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:

Name/Address of Agency:

Signature of Applicant:	**Date:**

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION.

MEDICAL STATEMENT
Medical Statement for Adoptive Applicant
And all Household Members for Domestic Adoption

(This form to be completed by a licensed physician.)

Patient's name: _____

Date you last completed a physical exam of this individual:	Date you last treated this individual:
Do you provide medical services to this individual: ☐ Regularly ☐ Occasionally ☐ First Time	

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease that would be detrimental to the care of an adoptive child placed in his/her home? ☐ Yes ☐ No

2. Are there any chronic or serious disorders for which this individual has received treatment? ☐ Yes ☐ No

3. Is this individual currently taking medication? ☐ Yes ☐ No

4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to an adoptive child placed in his/her home? ☐ Yes ☐ No

5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? ☐ Yes ☐ No

If the answer to any of the above questions is YES, please explain: _____
_____
_____

6. In your opinion, does the individual have a normal life expectancy? _____

7. Physical Examination:

Weight:	Blood Pressure:	Pulse
Height:	Temperature:	Lungs:
Heart:	Abdomen:	Nervous System:

8. Laboratory Tests:

HIV:	Urinalysis:
Hep B:	Tine or Mantoux:
Hep C:	CBC:

9. Any recommendations for medical care? _____
_____

Please state your professional opinion regarding this individual's suitability as an adoptive parent from the standpoint of health, considering the individual's medical history as given on the medical statement completed by the individual and from knowledge you have of the individual. _____
_____
_____

Physician's Signature:	Date:	Name of Physician (Print or Type)
Physician's Work Address:	Physician's Work Phone Number	Physician's State License Number

STATEMENT OF NET WORTH

Name(s) _____

ASSETS		LIABILITIES AND NET WORTH	
Cash on hand and in Banks	$_____	Mortgage and real estate notes	$_____
Investments	$_____	Notes payable	$_____
Savings accounts	$_____	Credit card (balances)	$_____
Cash surrender value of life insurance	$_____		$_____
Other stocks and bonds	$_____		$_____
Real estate:			$_____
1. _____	$_____	Loans (balances)	
2. _____	$_____	_____	$_____
Automobiles	$_____	_____	$_____
	$_____	_____	$_____
Trucks, boats, planes	$_____	_____	$_____
Personal property	$_____		
TOTAL ASSETS	$_____	TOTAL LIABILITIES	$_____

NET WORTH* $_____

(*Net worth is the difference between Assets and Liabilities)

Dated this _____ day of _____, 20___.

_____ _____

Signature Signature

PARENTS' PROFILE AT A GLANCE

Please complete this form and return it to our office along with your application. **This information will be shown to original adoptive parents giving them preliminary information**. **Do not place your identifying information on this form unless you want all information given at the onset of your adoption.** Please be concise on comments, as space is limited. Please type or print the information. Thank you.

FIRST NAMES _____
LENGTH OF MARRIAGE _____
NUMBER OF CHILDREN _____
PARENTING PHILOSOPHY _____
_____
_____
_____
_____
_____

CHARACTERISTICS OF ADOPTIVE FAMILY MEMBERS

	FIRST APPLICANT	SECOND APPLICANT
Age and/or birth date		
Height		
Weight		
Build		
Hair color		
Eye color		
Birth order		
Siblings		
Personality		
Sense of humor		
Family role		
Most disliked chore		
Education		
Religion		
Occupation		
Favorite date with spouse		
Hobbies/interests		
Favorite color		
Food		
Restaurant		
Dessert		
Ice cream flavor		
Sport to play and/or watch		
Animal/pet		

	FIRST APPLICANT	SECOND APPLICANT
Music		
Book		
Author		
Movie		
TV show		
Toy/plaything		
Family activity		
Vacation spot		

CHILDREN IN THE HOME

Age and birth date		
Height		
Weight		
Build		
Hair color		
Eye color		
Birth order		
Adopted Or biological		
Personality		
Sense of humor		
Most disliked chore		
Grade		
Hobbies/interests		
Favorite color		
Food		
Restaurant		
Dessert		
Ice cream flavor		
Sport to play and/or watch		
Animal/pet		
Music		
Book		
Author		
Movie		
TV show		
Toy/plaything		
Family activity		
Vacation spot		

HEALTH HISTORY INFORMATION OF ADOPTIVE APPLICANTS

Please each fill out a separate form. Thank you.

NAME: _____

MENTAL HEALTH

Have you or anyone in your family received counseling or other mental health treatment? _____ If yes, please provide additional information, including date(s), reason for care, and medications prescribed. _____
_____
_____
_____

PHYSICAL HEALTH

Describe your general health _____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following childhood diseases you have had:

____ Measles	____ Rubella (3 days)	____ Rubella (2 weeks)
____ Mumps	____ Chicken Pox	____ Whooping Cough
____ Roseola	____ Asthma	____ Hay fever
____ Encephalitis	____ Meningitis	____ Ear infections
____ Heart murmur	____ Scarlet Fever	____ Rheumatic fever
____ Urinary/bladder infections		

___ Other (specify) _____
_____

Have you had any major surgeries? If yes, please provide reasons and dates.
_____
_____
_____
_____
_____

HEALTH HISTORY
SELF, YOUR PARENTS, AND OTHER RELATIVES

Indicate by checking the appropriate box if you or any relatives (for example, your parents, brothers, sisters, aunts, uncles, grandparents, children, etc.), have or have had any of the medical conditions listed below. If yes, please indicate that person's relationship to you and complete the COMMENTS section. If a medical condition resulted in the death of a family member, please indicate and give the person's approximate age at the time of death in the COMMENTS section.

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
CONGENITAL IMPAIRMENTS Club foot or any orthopedic problem (i.e., flat footed, etc.)			
Harelip (cleft lip) or cleft palate			
Downs Syndrome			
Other chromosome abnormality			
Hydrocephalus			
Muscular Dystrophy			Areas affected and age at onset
Dwarfism			
Spina Bifida			
Congenital heart defect			
Tay-Sachs Disease			
ALLERGIES Eczema or other skin condition			Treatment or medication received
Hay fever			
Medication allergy			To what medication?
Food allergy			To what foods?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS Blindness, Glaucoma, color blindness, or other visual problems			
Corrective glasses or contact lenses			At what age were prescription lenses necessary?
Farsighted or nearsighted			
Astigmatism (inability to focus)			
Strabismus (cross-eye)			
Other (explain)			
Braces on teeth or other orthodontic work			What orthodontic work and for how long?
Deafness or other ear problems			Special education? Age at onset
Speech problems			Special education? Age at onset
Learning disability			Any diagnosis/hospitalization?
Retardation - mental or physical			Any diagnosis/hospitalization?
CIRCULATORY DISORDERS Hemophilia			
Sickle Cell Anemia or trait			
Hypertension (high blood pressure)			Age at onset, what treatment? Hospitalization?
Stroke			Age, treatment?
Heart Attack (coronary)			Age, treatment?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Arthritis			What kind? Age at onset and areas affected
Hepatitis			What type? Age at onset and treatment
Kidney disease			Age at onset and treatment
HORMONAL DISORDERS Diabetes			Age at onset and treatment
Thyroid Disorder			Age at onset and treatment
Obesity (overweight)			Age at onset and treatment
RESPIRATORY DISORDERS Asthma			Treatment
Tuberculosis			What kind and age at onset
Emphysema			Age at onset
MENTAL AND BEHAVIORAL DISORDERS Diagnosed Schizophrenia			Age at onset and treatment. Hospitalization?
Diagnosed Manic Depressive			Treatment
Other mental illness			**Describe, using additional** paper if necessary
Alcoholism or heavy drinking			Treatment/hospitalization?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Drug usage			Kind, amount and when taken?
LYMPHATIC DISORDERS Cancer			Kind, age at onset, areas affected
Tumors			Kind, age at onset, areas affected
Cystic Fibrosis			Age at onset, areas affected
Hodgkin's Disease			Age at onset, areas affected
NERVOUS SYSTEM DISORDERS Multiple Sclerosis			Age at onset, areas affected
Huntington's Disease			Age at onset, areas affected
Cerebral Palsy			Age at onset
Seizures or convulsions			Frequency, age at onset, what treatment
Epilepsy			Frequency, age at onset, what treatment
INFECTION, HOSPITALIZATION Repeated attacks of fever with known Infection			Diagnosis
Repeated severe infection necessitating hospitalization			Diagnosis
Hospitalization, operation or injury			When and for what

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
OTHER MEDICAL OR HEALTH PROBLEMS			Describe

_____ _____

Signature Date

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NAME: _____

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_____
_____
_____

PHYSICAL HEALTH

Describe your general health _____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following childhood diseases you have had:

____ Measles	____ Rubella (3 days)	____ Rubella (2 weeks)
____ Mumps	____ Chicken Pox	____ Whooping Cough
____ Roseola	____ Asthma	____ Hay fever
____ Encephalitis	____ Meningitis	____ Ear infections
____ Heart murmur	____ Scarlet Fever	____ Rheumatic fever
____ Urinary/bladder infections		

___ Other (specify) _____
_____

Have you had any major surgeries? If yes, please provide reasons and dates.
_____
_____
_____
_____
_____

HEALTH HISTORY
SELF, YOUR PARENTS, AND OTHER RELATIVES

Indicate by checking the appropriate box if you or any relatives (for example, your parents, brothers, sisters, aunts, uncles, grandparents, children, etc.), have or have had any of the medical conditions listed below. If yes, please indicate that person's relationship to you and complete the COMMENTS section. If a medical condition resulted in the death of a family member, please indicate and give the person's approximate age at the time of death in the COMMENTS section.

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Muscular Dystrophy			Areas affected and age at onset
Dwarfism			
Spina Bifida			
Congenital heart defect			
Tay-Sachs Disease			
ALLERGIES Eczema or other skin condition			Treatment or medication received
Hay fever			
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Food allergy			To what foods?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
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Corrective glasses or contact lenses			At what age were prescription lenses necessary?
Farsighted or nearsighted			
Astigmatism (inability to focus)			
Strabismus (cross-eye)			
Other (explain)			
Braces on teeth or other orthodontic work			What orthodontic work and for how long?
Deafness or other ear problems			Special education? Age at onset
Speech problems			Special education? Age at onset
Learning disability			Any diagnosis/hospitalization?
Retardation - mental or physical			Any diagnosis/hospitalization?
CIRCULATORY DISORDERS Hemophilia			
Sickle Cell Anemia or trait			
Hypertension (high blood pressure)			Age at onset, what treatment? Hospitalization?
Stroke			Age, treatment?
Heart Attack (coronary)			Age, treatment?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Arthritis			What kind? Age at onset and areas affected
Hepatitis			What type? Age at onset and treatment
Kidney disease			Age at onset and treatment
HORMONAL DISORDERS Diabetes			Age at onset and treatment
Thyroid Disorder			Age at onset and treatment
Obesity (overweight)			Age at onset and treatment
RESPIRATORY DISORDERS Asthma			Treatment
Tuberculosis			What kind and age at onset
Emphysema			Age at onset
MENTAL AND BEHAVIORAL DISORDERS Diagnosed Schizophrenia			Age at onset and treatment. Hospitalization?
Diagnosed Manic Depressive			Treatment
Other mental illness			**Describe, using additional** paper if necessary
Alcoholism or heavy drinking			Treatment/hospitalization?

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Drug usage			Kind, amount and when taken?
LYMPHATIC DISORDERS Cancer			Kind, age at onset, areas affected
Tumors			Kind, age at onset, areas affected
Cystic Fibrosis			Age at onset, areas affected
Hodgkin's Disease			Age at onset, areas affected
NERVOUS SYSTEM DISORDERS Multiple Sclerosis			Age at onset, areas affected
Huntington's Disease			Age at onset, areas affected
Cerebral Palsy			Age at onset
Seizures or convulsions			Frequency, age at onset, what treatment
Epilepsy			Frequency, age at onset, what treatment
INFECTION, HOSPITALIZATION Repeated attacks of fever with known Infection			Diagnosis
Repeated severe infection necessitating hospitalization			Diagnosis
Hospitalization, operation or injury			When and for what

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
OTHER MEDICAL OR HEALTH PROBLEMS			Describe

_____ _____

Signature Date

QUESTIONS FOR BIRTH MOTHERS

Please answer the following questions as thoroughly as you can. Your answers will be given to your birth mother so she can have an idea of what kind of parents you will be and how you plan to raise your child. Please do not include your name on this document. **We will not delete identifying information from this or any other form if the adoptive parents place the information on this form.**

First Names: _____

1. When do you plan to tell your child he/she was adopted? How will you approach this subject? _____
   _____
   _____

2. What do you believe will be the effect on your adopted child if you have a biological child after your adoption? _____
   _____
   _____

3. If you already have children, how will the adoption of this child affect them?
   _____
   _____
   _____
   _____

4. How do you plan to discipline your child? _____
   _____
   _____
   _____

5. What are your educational goals for your child? _____
   _____
   _____
   _____

6. How will you react if your child does not achieve this goal? _____
   _____
   _____
   _____

7. What will you do if a physical or mental handicap develops? _____
   _____
   _____
   _____

8. What is your plan for religious training? _____
_____
_____
_____

9. Have you given care to children in your home prior to your plan to adopt?
_____
_____
_____
_____

10. Why do you want to adopt? _____
_____
_____
_____

11. If you are adopting a child of another race or nationality, how do you plan to preserve your child's ethnic and cultural heritage? _____
_____
_____
_____

PROSPECTIVE ADOPTIVE PARENT QUESTIONNAIRE

Please each fill out a separate form. This form will NOT be shown to the birth mother.

Name: _____ Date: _____

1. Describe yourself (hair, eyes, height, weight, complexion, personality).

_____

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2. Describe your spouse's personality.

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3. If you have children, describe their physical appearances and personalities.

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4. Do you have pets? If so, what types?

5. What do you feel are the strong points in your marriage?

6. What qualities do you appreciate most in your spouse?

7. If you could change anything about him/her, what would it be?

8. Describe your views and approaches to parenting, including discipline.

9. What activities do you enjoy sharing with your spouse?

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10. What activities do you enjoy separately from your spouse?

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11. What things do you do for fun as a family?

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12. What goals are you working toward in your marriage?

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13. Why are you applying for adoption?

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14. At this time, what type of child do you feel you can parent?

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15. What are the experiences and strengths you feel you have that will enable you to parent this type of child?

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16. What are your expectations for this child?

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17. How will you handle the situation if your child does not meet your expectations?

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18. What things could you absolutely not accept in a child, and why?

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19. What are your views on religion, and what is its role in your life?

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20. If you are working outside of the home, what is your child care plan?

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21. What is your greatest fear concerning adoption?

_____

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PROSPECTIVE ADOPTIVE PARENT QUESTIONNAIRE

Please each fill out a separate form. This form will NOT be shown to the birth mother.

Name: _____ Date: _____

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21. What is your greatest fear concerning adoption?

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Use of Electronic Profile

We, _____, hereby authorize Adoption Choices of Oklahoma to use pictures of our family on its website.

By signing this release of information, we understand that we are only providing consent to Adoption Choices of Oklahoma for the use of our electronic profile. Any and all other agencies operating with a name similar to Adoption Choices of Oklahoma are considered separate agencies. This includes, but is not limited to, Adoption Choices, Inc. a 501 (C)(3) Not for Profit Colorado Corporation, Adoption Choices of Texas, Adoption Choices of Arizona, and Adoption Choices of Kansas. The aforementioned agencies and Adoption Choices of Oklahoma network to afford greater opportunities of matching between potential birth mothers and prospective adoptive families but operate individually under separate boards and as individual corporations.

Dated this _____ day of _____, 2015.