



To: _____

Date: _____

Welcome to the Adoption Alliance

Thank you for contacting The Adoption Alliance concerning your adoption plan. We understand this is a challenging time for you and we are here to help you through it. We have assisted many birth parents facing similar circumstances and have been able to make the adoption process a positive experience for them. We want to do the same for you!

Please review our information packet and please don't hesitate to contact us at **1-800-626-4324** if you have any questions or concerns. If you decide to make an adoption plan through our agency, complete the enclosed forms and return them to the agency at your earliest convenience. We look forward to assisting you!

Turn an Unplanned Pregnancy into a Miracle

If you find yourself with an unplanned pregnancy, you may have feelings of shock, denial, and uncertainty. It's not uncommon to feel that your only options are abortion or raising your child on your own. There are other options; the miracle of adoption.

The best thing you can do is to educate yourself about your options and feel confident that you have found the solution that is right for you. We realize there are many circumstances that influence your decision and we work hard to help you understand all of your options.

At The Adoption Alliance, we will guide you through all the aspects of an adoption plan. Our services to expectant parents are free, confidential, and available to anyone experiencing an unplanned pregnancy.

Making an Adoption Plan

Adoption is an unselfish gift of love from you to your child and to the adoptive parents. It is the ultimate and most generous gift. Only mothers who love their babies very deeply and want the best possible life for them will even consider adoption as an alternative.

Every woman who considers adoption as an option for her child has many questions that need to be answered. She is also facing a range of emotions as she weighs her choices. The Adoption Alliance provides guidance for women facing this difficult decision. Our goal is to assist you in making the decision that's right for you.

The Adoption Alliance, as a licensed agency, can provide birth mothers who choose adoption with financial assistance, and support services, all at no cost to the birth mother. You will never be pressured by caseworker to place your child for adoption.

The Adoption Alliance seeks to help each birth mother not just with an adoption plan, but with an overall life plan. Our hope is that the experience will be one of learning, growth, giving, and, perhaps, a fresh start.

Begin by asking yourself these hard questions:

- Will I be able to provide for my child financially?
- Would I have to depend on my parents or friends to take over for me?
- Can I parent a child and still meet my own needs? Finish school? Start a career?
- As a single parent, what kind of life will I be able to give my child?
- Do I understand the daily demands of childcare?
- Can I work all day to afford childcare, rent groceries, etc. and adequately raise my child?

An Adoption Alliance case worker will help you get all the information you need to consider making an adoption plan and answer any questions you may have.

Frequently Asked Questions by Birth Parents

What is adoption?

Adoption is the legal placement of a child with an adoptive family.

Will the adoption plan cost me anything?

Our services to birth parents are free of charge. Depending on your needs, the Adoption Alliance may arrange for payment of certain financial assistance. The Adoption Alliance can also make arrangements to help you cover necessary living expenses such as housing, food, clothing, and pregnancy related transportation. Also, birth mothers without access to medical insurance or Medicaid are eligible for pregnancy related medical assistance.

How long will I receive financial assistance?

Financial assistance continues for six weeks after the birth.

Can I help pick the adoptive parents for my baby?

Yes. You will have the opportunity to select the adoptive family for your child by viewing profiles either on the Adoption Alliance website or in hard copy. If you are not comfortable selecting an adoptive family we can choose a family for you.

How will I know my baby is in a good home?

The Adoption Alliance has an extensive screening process for prospective adoptive parents to ensure that you have the best families to choose from. Every family has an adoption profile for you to review. If you want to know more about the adoptive family we will allow you to meet and talk to the adoptive parents prior to placement.

Will I have contact with my child after the adoption?

You will have the option of receiving at least five pictures and a letter once a month for the first 6 months following placement. After the first six months, you can receive at least five pictures and a letter once a year for the first five years.

Can I have a closed adoption?

Yes, of course. If you do not want contact with your child after placement, your wishes will be honored. We encourage you to select the adoptive parents and have at least one phone conversation in order establish a comfort level, but this is completely your decision.

What if I don't live in Texas?

If you would like to place your child with one of The Adoption Alliance families and you don't live in Texas, we can still help you.

If I am a minor, do I need my parents' permission?

No, according to the Texas Family Code, "An affidavit for voluntary relinquishment of parental rights must be signed after the birth of the child, but not before 48 hours after

the birth of the child, by the parent, whether or not a minor, whose parental rights are to be relinquished". However, in many cases we find that the adoption process can be less stressful if you are honest with family and friends concerning your decision.

Does the father of my baby have to be involved?

The Adoption Alliance can work with you, regardless of the relationship you have with your baby's father. At the Adoption Alliance, we encourage expectant fathers to take part in the adoption process. If the father does not wish to be involved, there are steps that the Adoption Alliance can take to ensure a legal adoption.

Can I change my mind after placement?

Once you sign the affidavit of relinquishment, your decision is final. Our goal is to help you reach a decision that you are comfortable with before you take that step.

Are there adoptive families available for older and minority children?

Yes. Families are available who are requesting and searching for these children.

Birth Parent Comments

The Adoption Alliance often receives comments from birth mothers who have worked with us during the adoption process. We are proud to share some of their comments with you.

"I just wanted to thank you and your office for everything. One of the hardest decisions I have ever had to make was made easier by your understanding and knowing that you really cared what happened to me, not just the baby. I couldn't have picked a better agency or a better family to place Matthew with. Everything you have done will help me to carry on with my life as normal despite such a momentous step. Thank you so much and I hope we will continue to keep in touch so you can see the success I know I will attain. All the best for the coming years and all birth mothers you help along the way. May God bless them and you."

"I just want to say thank you for helping me through these past few months. Your guidance has been key to my sanity throughout this process! Also, I can tell that you really do care and that you're not just doing a job. You do have a gift and you're using it well! I am really grateful for your presence in my life. Always remember that you are a blessing to others. Be good to yourself and God bless."

"I wanted to thank you again for everything that you've done for me. If it hadn't been for you, I doubt if I could have made it through this situation."



BIRTHMOTHER'S GENETIC, SOCIAL & MEDICAL HISTORY

****Please Complete ALL Sections of this Form****

- If you don't know the information requested, write "**unknown**" in the space provided.
- If the information requested does not apply to your situation, write "**N/A**" (not applicable) in the space provided.

How were you referred to the Adoption Alliance? _____

Estimated Due Date: _____

General Information

Name (first, middle, last): _____ Maiden name: _____

Date of Birth: _____ Place of Birth: _____

Social security #: _____ Driver's license #: _____ State: _____

Current address (street, city, state, zip): _____ Apt. #: _____

Cell phone #: _____ Home phone #: _____

Work phone # _____ Other phone #: _____

Email address: _____

Emergency Contact: _____ Phone #: _____

Notes: _____

Physical Description

Height: _____ Usual weight: _____ Eye color: _____ Skin Complexion: _____

Natural hair color: _____ Natural hair texture: _____

Ethnicity: Caucasian Hispanic Asian African American Native American Indian

Other, please explain: _____

Special Interests and Favorites

Hobbies: _____

Talents: _____

Other Interest: _____

My role model is: _____ Favorite Animal: _____

Favorite Food: _____ Favorite Color: _____

Favorite T.V. Show: _____ Favorite Place: _____

Favorite Thing about Yourself: _____

Indian Heritage

Any child having substantial Native American Indian heritage, must by law have a release from their tribe before being placed for adoption. Consequently, if you are a member of an Indian tribe, the Adoption Alliance may need to contract the appropriate tribe.

Please initial **ONE** of the statements which best applies to your situation:

- _____ 1. To my knowledge, there is **NO** American Indian heritage in my family.
- _____ 2. I have **SOME** American Indian heritage, but I am not a registered member of a tribe.
- _____ 3. Yes, I am a registered member of a Native American Indian tribe.

Tribe Name: _____ Card #: _____

Birth Parent Signature: _____ **Date:** _____

Education and Employment

Last grade completed in school: _____ Presently in school? Yes No

Extra curricular activities: _____ Favorite subject: _____

Present employment: _____ Length of employment: _____

Occupational goals in the future: _____

Medicaid and Medical Insurance

Do you have Medicaid? Yes No Will it cover your pregnancy? Yes No

What is your Medicaid number? _____

Please provide a copy of your Medicaid or Insurance information to the agency.

Do you have medical insurance? Yes No Will it cover your pregnancy? Yes No

Name of insurance carrier: _____

Name of Insured: _____ Policy #: _____ Group #: _____

Family History

Were You Adopted? Yes No If Yes, Date of Adoption: _____

Agency's name / Attorney's Name: _____

Your Biological Parents	<u>Mother</u>	<u>Father</u>
Name:		
Phone #:		
Age:		
If deceased, age and cause		
Height:		
Weight:		
Eye color:		
Natural hair color:		
Ethnic background:		
Health:		
Aware of this pregnancy?	Yes No	Yes No
Aware of this adoption plan?	Yes No	Yes No
Supportive of adoption plan?	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

Your Brothers and Sisters	<u>Sibling 1</u>	<u>Sibling 2</u>	<u>Sibling 3</u>	<u>Sibling 4</u>
Gender:				
Age:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

******Please list additional siblings on the back of this page******

Your Grandparents	<u>Mom's Mom</u>	<u>Mom's Dad</u>	<u>Dad's Mom</u>	<u>Dad's Dad</u>
Age:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

Your Children	<u>Child 1</u>	<u>Child 2</u>	<u>Child 3</u>	<u>Child 4</u>
Gender:				
Full / half sibling to adoptee?				
Name:				
Full term or premature birth				
Date of birth:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Does the child live with you?	Yes No	Yes No	Yes No	Yes No
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Does the child live with you, please explain: _____

Do you have any objections to the adoptive parents sharing information concerning your other children with this child?
 Yes No

If Yes, Please explain: _____

******Please list additional children on the back of this page******

Medical History

	<u>During Pregnancy</u>	<u>Prior to Pregnancy</u>
Alcohol	Yes No	Yes No
Amphetamines (uppers)	Yes No	Yes No
Barbiturates (downers)	Yes No	Yes No
Cocaine	Yes No	Yes No
Crack	Yes No	Yes No
Ecstasy	Yes No	Yes No
Heroin	Yes No	Yes No
Intervenes drug usage	Yes No	Yes No
LSD	Yes No	Yes No
Marijuana	Yes No	Yes No
PCP	Yes No	Yes No
Tobacco	Yes No	Yes No
Other _____	Yes No	Yes No
Other _____	Yes No	Yes No
Prescription Drugs		
_____	Yes No	Yes No
_____	Yes No	Yes No
_____	Yes No	Yes No
Non-prescription Drugs		
_____	Yes No	Yes No
_____	Yes No	Yes No
_____	Yes No	Yes No
Virus and Infections		
Chlamydia	Yes No	Yes No
Genital Warts	Yes No	Yes No
Gonorrhea	Yes No	Yes No
Herpes	Yes No	Yes No
Hepatitis C	Yes No	Yes No
HIV	Yes No	Yes No
Syphilis	Yes No	Yes No
Other _____	Yes No	Yes No

Medical History Continued

Please circle "YES" or "NO" or "UNKNOWN" beside the following medical conditions. This will include you and your immediate relatives, such as your brothers and sisters, your parents and your grandparents, and/or your other children.

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Alcoholism	Yes No	Yes No Unknown	
Allergies:	Yes No	Yes No Unknown	
Hay Fever	Yes No	Yes No Unknown	
Food	Yes No	Yes No Unknown	
Local Anesthetic	Yes No	Yes No Unknown	
Penicillin	Yes No	Yes No Unknown	
Antibiotics	Yes No	Yes No Unknown	
Sulfa Drugs	Yes No	Yes No Unknown	
Codeine	Yes No	Yes No Unknown	
Aspirin	Yes No	Yes No Unknown	
Mercury	Yes No	Yes No Unknown	
Drug Allergy	Yes No	Yes No Unknown	
Wasp or Bee	Yes No	Yes No Unknown	
Other Allergies	Yes No	Yes No Unknown	
Anemia	Yes No	Yes No Unknown	
Arthritis	Yes No	Yes No Unknown	
Asthma	Yes No	Yes No Unknown	
Blindness	Yes No	Yes No Unknown	
Cataracts	Yes No	Yes No Unknown	
Crossed eyes	Yes No	Yes No Unknown	
Blood Disorders:	Yes No	Yes No Unknown	
Diabetes	Yes No	Yes No Unknown	
Hemophilia	Yes No	Yes No Unknown	
RH negative	Yes No	Yes No Unknown	
High Blood Pressure	Yes No	Yes No Unknown	
Low Blood Pressure	Yes No	Yes No Unknown	
Other	Yes No	Yes No Unknown	
Cancer	Yes No	Yes No Unknown	
Cerebral Palsy	Yes No	Yes No Unknown	
Chromosome Disorder	Yes No	Yes No Unknown	
Cleft Palate	Yes No	Yes No Unknown	

Medical History Continued

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Club Foot	Yes No	Yes No Unknown	
Crippling Disorder	Yes No	Yes No Unknown	
Cystic Fibrosis	Yes No	Yes No Unknown	
Deafness	Yes No	Yes No Unknown	
Dental problems	Yes No	Yes No Unknown	
Diseases:	Yes No	Yes No Unknown	
AIDS	Yes No	Yes No Unknown	
Alzheimer's	Yes No	Yes No Unknown	
Hodgkin's	Yes No	Yes No Unknown	
Huntington's	Yes No	Yes No Unknown	
Kidney	Yes No	Yes No Unknown	
Liver	Yes No	Yes No Unknown	
Tay-Sachs	Yes No	Yes No Unknown	
Venereal	Yes No	Yes No Unknown	
Downs Syndrome	Yes No	Yes No Unknown	
Drug Usage or Addiction	Yes No	Yes No Unknown	
Eczema or other Skin Condition	Yes No	Yes No Unknown	
Epilepsy	Yes No	Yes No Unknown	
Glaucoma	Yes No	Yes No Unknown	
Harelip	Yes No	Yes No Unknown	
Heart:	Yes No	Yes No Unknown	
Cardiovascular	Yes No	Yes No Unknown	
Problems	Yes No	Yes No Unknown	
Congenital	Yes No	Yes No Unknown	
Heart Defect	Yes No	Yes No Unknown	
Heart Attack	Yes No	Yes No Unknown	
Heart Disease	Yes No	Yes No Unknown	
Hormone Disorder	Yes No	Yes No Unknown	
Hysterectomy or other Female Disorder	Yes No	Yes No Unknown	
Hydrocephalus	Yes No	Yes No Unknown	
Learning Disability	Yes No	Yes No Unknown	
Hyperactivity	Yes No	Yes No Unknown	
Attention Deficit	Yes No	Yes No Unknown	
Disorder	Yes No	Yes No Unknown	

Medical History Continued

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Leukemia	Yes No	Yes No Unknown	
Malformations	Yes No	Yes No Unknown	
Manic Depressive	Yes No	Yes No Unknown	
Emotional Distress	Yes No	Yes No Unknown	
Mental Retardation	Yes No	Yes No Unknown	
Multiple Sclerosis	Yes No	Yes No Unknown	
Muscular Dystrophy	Yes No	Yes No Unknown	
Paralysis	Yes No	Yes No Unknown	
Schizophrenia	Yes No	Yes No Unknown	
Seizures/Convulsions	Yes No	Yes No Unknown	
Sickle Cell Anemia or Trait	Yes No	Yes No Unknown	
Speech Problems	Yes No	Yes No Unknown	
Spina Bifida	Yes No	Yes No Unknown	
Stroke	Yes No	Yes No Unknown	
Thyroid Disorder	Yes No	Yes No Unknown	
Tuberculosis	Yes No	Yes No Unknown	
Tumors	Yes No	Yes No Unknown	

Have you ever seen a psychologist, psychiatrist, or any other mental health professional? Yes No

Name of provider: _____

If Yes, date of last visit: _____ Reason for visit: _____

Name of provider: _____

If Yes, date of last visit: _____ Reason for visit: _____

Special notes regarding medical history: _____

A child's medical background can be very important (especially if the child should become ill) therefore, the above information WILL BE shared with the child's adoptive parents and the child's pediatrician. It is very important to the child that this information be complete.

Pregnancy History

Have you had **ANY** complications during this pregnancy? Yes No

If Yes, Please explain: _____

Have you had **ANY** complications during any other pregnancy? Yes No

If Yes, Please explain: _____

Have you been involved in any accidents during this pregnancy? Yes No

If Yes, Please explain: _____

Has anyone abused you during this pregnancy? Yes No

If Yes, Please explain: Who: _____ Date: _____ Location: _____

Why: _____

Describe incident: _____

Did you call the police? Yes No

What actions were taken? _____

Did you get medical attention? Yes No

If Yes, Please explain: _____

Have you had prenatal care during this pregnancy? Yes No

If Yes, Please provide: OB/GYN or Clinic: _____

Doctor's Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Contact Name: _____

Date / Time of Next Appointment: _____

Pregnancy History Continued

Special Test Performed:

Date

Pregnancy Test (Blood)	Yes	No	_____
Pregnancy Test (Urine)	Yes	No	_____
Sonogram	Yes	No	_____
Blood Work	Yes	No	_____
Drug Screen	Yes	No	_____
Alcohol Screen	Yes	No	_____
Amniocentesis	Yes	No	_____
VDRL (Venereal Disease Screen)	Yes	No	_____
AIDS Test	Yes	No	_____
Tuberculosis	Yes	No	_____
Other _____			_____

We will provide the adoptive parents with copies of all medical and genetic information. The adoptive parents will provide this information to the baby's pediatrician, giving a very clear picture of the baby's medical history. This information will be very helpful to the baby and his/her pediatrician as the baby grows up.

General Questions

Do you have a roommate? Yes No

If Yes, is the roommate aware of your adoption plan? Yes No

What is your religion? _____

Do you have a preference concerning the religious faith of the adoptive parents? Yes No

If Yes, Please Explain: _____

Are you a Citizen of the United States? Yes No

If No, What is your citizenship? _____

General Questions Continued

Have you **EVER** been arrested? Yes No

If Yes, Please explain: _____

Are you currently on parole/probation? Yes No

If Yes, Please explain: _____

Is there any significant event in your life, past or present, we should be aware of? (i.e. Emotional problems, abusive situations, legal problems, drug and/or alcohol related problems, prior adoptions, counseling, psychiatric care, medical illnesses or problems)

Did you consider any other plan for this child? Yes No

Why did you decide adoption was the best plan? _____

What are your plans after this pregnancy? _____

Are you aware counseling is available to you concerning your adoption plan...

...during your pregnancy?	Yes	No
...after you give birth?	Yes	No
...during your post-partum period?	Yes	No

Do you feel you currently need counseling concerning your adoption plan? Yes No

I wish to state that I have voluntarily provided the information herein. I have completed the forms as accurately as possible. I have not intentionally omitted any information. THE ADOPTION ALLIANCE may share with the prospective adoptive parents of my child and/or their legal representative:

- (1) the information in this form,
- (2) medical and psychological information (past and present),
- (3) information concerning me, including lab results, medical charts, counseling notes, progress notes and/or verbal information received from my physicians, counselors or hospitals.

I understand that where necessary, this information will be included with material sent to the Interstate Compact offices, in compliance with the laws regarding the Interstate Placement of Children.

I understand all documentation concerning the adoption plan for this child will may be filed with the District Court in San Antonio, Bexar County, Texas.

PLEASE SIGN YOUR NAME BELOW:

SIGNATURE: _____

DATE: _____



BIRTFATHER'S GENETIC, SOCIAL & MEDICAL HISTORY

****Please Complete **ALL** Sections of this Form****

- If you don't know the information requested, write "**unknown**" in the space provided.
- If the information requested does not apply to your situation, write "**N/A**" (not applicable) in the space provided.

How were you referred to the Adoption Alliance? _____

Estimated Due Date: _____

General Information

Name (first, middle, last): _____ Maiden name: _____

Date of Birth: _____ Place of Birth: _____

Social security #: _____ Driver's license #: _____ State: _____

Current address (street, city, state, zip): _____ Apt. #: _____

Cell phone #: _____ Home phone #: _____

Work phone # _____ Other phone #: _____

Email address: _____

Emergency Contact: _____ Phone #: _____

Notes: _____

Physical Description

Height: _____ Usual weight: _____ Eye color: _____ Skin Complexion: _____

Natural hair color: _____ Natural hair texture: _____

Ethnicity: Caucasian Hispanic Asian African American Native American Indian

Other, please explain: _____

Special Interests and Favorites

Hobbies: _____

Talents: _____

Other Interest: _____

My role model is: _____ Favorite Animal: _____

Favorite Food: _____ Favorite Color: _____

Favorite T.V. Show: _____ Favorite Place: _____

Favorite Thing about Yourself: _____

Indian Heritage

Any child having substantial Native American Indian heritage, must by law have a release from their tribe before being placed for adoption. Consequently, if you are a member of an Indian tribe, the Adoption Alliance may need to contract the appropriate tribe.

Please initial **ONE** of the statements which best applies to your situation:

- _____ 1. To my knowledge, there is **NO** American Indian heritage in my family.
- _____ 2. I have **SOME** American Indian heritage, but I am not a registered member of a tribe.
- _____ 3. Yes, I am a registered member of a Native American Indian tribe.

Tribe Name: _____ Card #: _____

Birth Parent Signature: _____ **Date:** _____

Education and Employment

Last grade completed in school: _____ Presently in school? Yes No

Extra curricular activities: _____ Favorite subject: _____

Present employment: _____ Length of employment: _____

Occupational goals in the future: _____

Birth Mothers Information

1. The mother of my child is: _____
2. Do you live with the birth mother? Yes No
3. Is the birth mother supportive of the adoption plan? Yes No
4. If you answered No to #6 above, please explain: _____

Height: _____ Usual Weight: _____ Eye color: _____ Skin Complexion: _____

Natural hair color: _____ Natural hair texture: _____

Ethnicity: Caucasian Hispanic Asian African American Native American Indian
 Other, please explain: _____

Marital Status

Single: Yes No

Married: Yes No

Name: _____ Date of marriage: _____

Address: _____ Phone #: _____

Place of marriage: _____ Children born of this marriage: _____

Divorced: Yes No

Name: _____ Date of marriage: _____

Address: _____ Phone #: _____

Place of Marriage: _____ Children born of this marriage: _____

If Widowed: Name: _____ Date of death: _____

Medicaid and Medical Insurance

Do you have Medicaid? Yes No Will it cover the pregnancy? Yes No

What is your Medicaid number? _____

Please provide a copy of your Medicaid or Insurance information to the agency.

Do you have medical insurance? Yes No Will it cover the pregnancy? Yes No

Name of insurance carrier: _____

Name of Insured: _____ Policy #: _____ Group #: _____

Family History

Were You Adopted? Yes No If Yes, Date of Adoption: _____

Agency's name / Attorney's Name: _____

Your Biological Parents	<u>Mother</u>	<u>Father</u>
Name:		
Phone #:		
Age:		
If deceased, age and cause		
Height:		
Weight:		
Eye color:		
Natural hair color:		
Ethnic background:		
Health:		
Aware of this pregnancy?	Yes No	Yes No
Aware of this adoption plan?	Yes No	Yes No
Supportive of adoption plan?	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

Your Brothers and Sisters	<u>Sibling 1</u>	<u>Sibling 2</u>	<u>Sibling 3</u>	<u>Sibling 4</u>
Gender:				
Age:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

******Please list additional siblings on the back of this page******

Your Grandparents	<u>Mom's Mom</u>	<u>Mom's Dad</u>	<u>Dad's Mom</u>	<u>Dad's Dad</u>
Age:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Supportive of Plan, please explain: _____

Your Children	<u>Child 1</u>	<u>Child 2</u>	<u>Child 3</u>	<u>Child 4</u>
Gender:				
Full / half sibling to adoptee?				
Name:				
Full term or premature birth				
Date of birth:				
If deceased, age and cause				
Height:				
Weight:				
Eye color:				
Natural hair color:				
Ethnic background:				
Health:				
Does the child live with you?	Yes No	Yes No	Yes No	Yes No
Aware of pregnancy?	Yes No	Yes No	Yes No	Yes No
Aware of adoption plan?	Yes No	Yes No	Yes No	Yes No
Supportive of plan?	Yes No	Yes No	Yes No	Yes No

If NO to Does the child live with you, please explain: _____

Do you have any objections to the adoptive parents sharing information concerning your other children with this child?

Yes No

If Yes, Please explain: _____

******Please list additional children on the back of this page******

Medical History

	<u>During Pregnancy</u>	<u>Prior to Pregnancy</u>
Alcohol	Yes No	Yes No
Amphetamines (uppers)	Yes No	Yes No
Barbiturates (downers)	Yes No	Yes No
Cocaine	Yes No	Yes No
Crack	Yes No	Yes No
Ecstasy	Yes No	Yes No
Heroin	Yes No	Yes No
Intervenes drug usage	Yes No	Yes No
LSD	Yes No	Yes No
Marijuana	Yes No	Yes No
PCP	Yes No	Yes No
Tobacco	Yes No	Yes No
Other _____	Yes No	Yes No
Other _____	Yes No	Yes No
Prescription Drugs		
_____	Yes No	Yes No
_____	Yes No	Yes No
_____	Yes No	Yes No
Non-prescription Drugs		
_____	Yes No	Yes No
_____	Yes No	Yes No
_____	Yes No	Yes No
Virus and Infections		
Chlamydia	Yes No	Yes No
Genital Warts	Yes No	Yes No
Gonorrhea	Yes No	Yes No
Herpes	Yes No	Yes No
Hepatitis C	Yes No	Yes No
HIV	Yes No	Yes No
Syphilis	Yes No	Yes No
Other _____	Yes No	Yes No

Medical History Continued

Please circle "YES" or "NO" or "UNKNOWN" beside the following medical conditions. This will include you and your immediate relatives, such as your brothers and sisters, your parents and your grandparents, and/or your other children.

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Alcoholism	Yes No	Yes No Unknown	
Allergies:	Yes No	Yes No Unknown	
Hay Fever	Yes No	Yes No Unknown	
Food	Yes No	Yes No Unknown	
Local Anesthetic	Yes No	Yes No Unknown	
Penicillin	Yes No	Yes No Unknown	
Antibiotics	Yes No	Yes No Unknown	
Sulfa Drugs	Yes No	Yes No Unknown	
Codeine	Yes No	Yes No Unknown	
Aspirin	Yes No	Yes No Unknown	
Mercury	Yes No	Yes No Unknown	
Drug Allergy	Yes No	Yes No Unknown	
Wasp or Bee	Yes No	Yes No Unknown	
Other Allergies	Yes No	Yes No Unknown	
Anemia	Yes No	Yes No Unknown	
Arthritis	Yes No	Yes No Unknown	
Asthma	Yes No	Yes No Unknown	
Blindness	Yes No	Yes No Unknown	
Cataracts	Yes No	Yes No Unknown	
Crossed eyes	Yes No	Yes No Unknown	
Blood Disorders:	Yes No	Yes No Unknown	
Diabetes	Yes No	Yes No Unknown	
Hemophilia	Yes No	Yes No Unknown	
RH negative	Yes No	Yes No Unknown	
High Blood Pressure	Yes No	Yes No Unknown	
Low Blood Pressure	Yes No	Yes No Unknown	
Other	Yes No	Yes No Unknown	
Cancer	Yes No	Yes No Unknown	
Cerebral Palsy	Yes No	Yes No Unknown	
Chromosome Disorder	Yes No	Yes No Unknown	
Cleft Palate	Yes No	Yes No Unknown	

Medical History Continued

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Club Foot	Yes No	Yes No Unknown	
Crippling Disorder	Yes No	Yes No Unknown	
Cystic Fibrosis	Yes No	Yes No Unknown	
Deafness	Yes No	Yes No Unknown	
Dental problems	Yes No	Yes No Unknown	
Diseases:	Yes No	Yes No Unknown	
AIDS	Yes No	Yes No Unknown	
Alzheimer's	Yes No	Yes No Unknown	
Hodgkin's	Yes No	Yes No Unknown	
Huntington's	Yes No	Yes No Unknown	
Kidney	Yes No	Yes No Unknown	
Liver	Yes No	Yes No Unknown	
Tay-Sachs	Yes No	Yes No Unknown	
Venereal	Yes No	Yes No Unknown	
Downs Syndrome	Yes No	Yes No Unknown	
Drug Usage or Addiction	Yes No	Yes No Unknown	
Eczema or other Skin Condition	Yes No	Yes No Unknown	
Epilepsy	Yes No	Yes No Unknown	
Glaucoma	Yes No	Yes No Unknown	
Harelip	Yes No	Yes No Unknown	
Heart:	Yes No	Yes No Unknown	
Cardiovascular	Yes No	Yes No Unknown	
Problems	Yes No	Yes No Unknown	
Congenital	Yes No	Yes No Unknown	
Heart Defect	Yes No	Yes No Unknown	
Heart Attack	Yes No	Yes No Unknown	
Heart Disease	Yes No	Yes No Unknown	
Hormone Disorder	Yes No	Yes No Unknown	
Hysterectomy or other Female Disorder	Yes No	Yes No Unknown	
Hydrocephalus	Yes No	Yes No Unknown	
Learning Disability	Yes No	Yes No Unknown	
Hyperactivity	Yes No	Yes No Unknown	
Attention Deficit	Yes No	Yes No Unknown	
Disorder	Yes No	Yes No Unknown	

Medical History Continued

	<u>Self</u>	<u>Relative</u>	<u>If Yes, name relative</u>
Leukemia	Yes No	Yes No Unknown	
Malformations	Yes No	Yes No Unknown	
Manic Depressive	Yes No	Yes No Unknown	
Emotional Distress	Yes No	Yes No Unknown	
Mental Retardation	Yes No	Yes No Unknown	
Multiple Sclerosis	Yes No	Yes No Unknown	
Muscular Dystrophy	Yes No	Yes No Unknown	
Paralysis	Yes No	Yes No Unknown	
Schizophrenia	Yes No	Yes No Unknown	
Seizures/Convulsions	Yes No	Yes No Unknown	
Sickle Cell Anemia or Trait	Yes No	Yes No Unknown	
Speech Problems	Yes No	Yes No Unknown	
Spina Bifida	Yes No	Yes No Unknown	
Stroke	Yes No	Yes No Unknown	
Thyroid Disorder	Yes No	Yes No Unknown	
Tuberculosis	Yes No	Yes No Unknown	
Tumors	Yes No	Yes No Unknown	

Have you ever seen a psychologist, psychiatrist, or any other mental health professional? Yes No

Name of provider: _____

If Yes, date of last visit: _____ Reason for visit: _____

Name of provider: _____

If Yes, date of last visit: _____ Reason for visit: _____

Special notes regarding medical history: _____

A child's medical background can be very important (especially if the child should become ill) therefore, the above information WILL BE shared with the child's adoptive parents and the child's pediatrician. It is very important to the child that this information be complete.

Pregnancy History

Has the birth mother had **ANY** complications during this pregnancy? Yes No

If Yes, Please explain: _____

Has the birth mother had **ANY** complications during any other pregnancy? Yes No

If Yes, Please explain: _____

Has the birth mother been involved in any accidents during this pregnancy? Yes No

If Yes, Please explain: _____

Has anyone abused the birth mother during this pregnancy? Yes No

If Yes, Please explain: Who: _____ Date: _____ Location: _____

Why: _____

Describe incident: _____

Did you call the police? Yes No

What actions were taken? _____

Did you get medical attention? Yes No

If Yes, Please explain: _____

Has the birth mother had prenatal care during this pregnancy? Yes No

If Yes, Please provide: OB/GYN or Clinic: _____

Doctor's Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Contact Name: _____

Date / Time of Next Appointment: _____

Pregnancy History Continued

Special Test Performed:

Date

Pregnancy Test (Blood)	Yes	No	_____
Pregnancy Test (Urine)	Yes	No	_____
Sonogram	Yes	No	_____
Blood Work	Yes	No	_____
Drug Screen	Yes	No	_____
Alcohol Screen	Yes	No	_____
Amniocentesis	Yes	No	_____
VDRL (Venereal Disease Screen)	Yes	No	_____
AIDS Test	Yes	No	_____
Tuberculosis	Yes	No	_____
Other _____			_____

We will provide the adoptive parents with copies of all medical and genetic information. The adoptive parents will provide this information to the baby's pediatrician, giving a very clear picture of the baby's medical history. This information will be very helpful to the baby and his/her pediatrician as the baby grows up.

General Questions

Do you have a roommate? Yes No

If Yes, is the roommate aware of your adoption plan? Yes No

What is your religion? _____

Do you have a preference concerning the religious faith of the adoptive parents? Yes No

If Yes, Please Explain: _____

Are you a Citizen of the United States? Yes No

If No, What is your citizenship? _____

General Questions Continued

Have you **EVER** been arrested? Yes No

If Yes, Please explain: _____

Are you currently on parole/probation? Yes No

If Yes, Please explain: _____

Is there any significant event in your life, past or present, we should be aware of? (i.e. Emotional problems, abusive situations, legal problems, drug and/or alcohol related problems, prior adoptions, counseling, psychiatric care, medical illnesses or problems)

Did you consider any other plan for this child? Yes No

Why did you decide adoption was the best plan? _____

What are your plans after this pregnancy? _____

Are you aware counseling is available to you concerning your adoption plan...

...during your pregnancy?	Yes	No
...after you give birth?	Yes	No
...during your post-partum period?	Yes	No

Do you feel you currently need counseling concerning your adoption plan? Yes No

I wish to state that I have voluntarily provided the information herein. I have completed the forms as accurately as possible. I have not intentionally omitted any information. THE ADOPTION ALLIANCE may share with the prospective adoptive parents of my child and/or their legal representative:

- (1) the information in this form,
- (2) medical and psychological information (past and present),
- (3) information concerning me, including lab results, medical charts, counseling notes, progress notes and/or verbal information received from my physicians, counselors or hospitals.

I understand that where necessary, this information will be included with material sent to the Interstate Compact offices, in compliance with the laws regarding the Interstate Placement of Children.

I understand all documentation concerning the adoption plan for this child will may be filed with the District Court in San Antonio, Bexar County, Texas.

PLEASE SIGN YOUR NAME BELOW:

SIGNATURE: _____

DATE: _____

**AUTHORIZATION FOR RELEASE OF
HEALTH & INSURANCE INFORMATION**

I, _____ (print name), hereby authorize:

- Medical Facility / Hospital: _____
- Physician: _____
- Insurance Provider: _____

to release and disclose medical information, Insurance information and or protected health information of the patient listed below. I also hereby consent to drug testing as deemed necessary by the Adoption Alliance or my medical professional. Please release any and all medical records, charts, lab or test results pertaining to me, my unborn child(ren) OR the now born child being. This information may be released to **The Adoption Alliance, 7303 Blanco Road, San Antonio, Texas, 78216, (210) 349-3991.**

Patients full name: _____

Social Security Number: _____

Date of birth: _____ Telephone #: _____

Address: _____

City, State, Zip: _____

Medicaid or Insurance #: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

REVOCACTION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature of Patient or Authorized Representative

Date

RESPONSIBILITIES
AND
STATEMENT OF UNDERSTANDING

My name is: _____

My due date is: _____

Please read each statement below and initial once you completely read and understand the meaning of each statement. Should you have any questions please contact the Adoption Alliance at 1-800-626-4324.

1. Your primary responsibility during your pregnancy is to remain healthy and to insure the health of your unborn child.

I understand this _____(initial)

2. You must follow all of the instructions given to you by your physician. Certain lab tests are required, which we will request of your physician. These tests include pregnancy verification, venereal disease screen, drug and alcohol screen, sonogram and an AIDS test. It is important for you to go to each scheduled medical appointment.

I understand this _____(initial)

3. State Law requires that you to complete a Genetic/Social History form that the Adoption Alliance must provided to the Adoptive Parents you have selected. This Genetic/Social History form will include information concerning you and your family and the birthfather and his family. It is very important that you provide as much information as possible about both yourself and the birthfather. If you are aware of any health problems you may have or which may be in your family or the birthfather's, you must provide this information in the Genetic/Social History form.

I understand this _____(initial)

4. You must sign a medical authorization and release of information form. This document allows the Adoption Alliance access to your medical records. State Law requires us to provide adoptive parents copies of all medical information concerning the child placed with them.

I understand this _____(initial)

5. The Adoption Alliance may provide payments for medical care that is related to your pregnancy. The Adoption Alliance is a private, non-profit agency. Therefore, the Adoption Alliance will strive to ascertain if medical benefits are available to biological parents (Medicaid or insurance) prior to payment of medical bills. If you have Medicaid or insurance benefits, you should provide the Adoption Alliance with the appropriate information.

I understand this _____(initial)

6. Based upon need and State guidelines, the Adoption Alliance, at its discretion, may assist birthparents with certain living expenses as outlined by State law.

I understand this _____(initial)

7. You should read this and all documents related to your adoption plan carefully. If you have any questions please call an Adoption Alliance counselor immediately.

I understand this _____(initial)

It is my plan to place my unborn child for adoption and have selected **THE ADOPTION ALLIANCE** as the Agency through which I wish to carry out my plan. I will abide by all of the terms and conditions set forth herein, the laws of my State governing adoptions, and the rules and regulations of this State.

SIGNATURE OF BIRTHMOTHER: _____ **DATE:** _____

CONTACT AND HOSPITAL STAY PREFERENCES

Please select the type of contact you want for your adoption plan and complete your preferences regarding your hospital plan. Remember your preferences may change at any time but you must complete a new Contact and Hospital Stay Preferences sheet to officially make your changes.

Contact Preferences

Phone Calls with the Adoptive Family	Meetings with the Adoptive Family	Pictures/Letters from the Adoptive Family
<input type="checkbox"/> Before Birth	<input type="checkbox"/> Before Birth <input type="checkbox"/> At the Hospital	<input type="checkbox"/> After Placement**
<input type="checkbox"/> Undecided	<input type="checkbox"/> Undecided	<input type="checkbox"/> Undecided
<input type="checkbox"/> No Calls	<input type="checkbox"/> No Meetings	<input type="checkbox"/> No Pictures

** Pictures and/or letters can be received once a month for the first six months after placement and also annually for the first five years after placement.

Hospital Stay Preferences

Hospital Name: _____ Address: _____

1. During my Labor I would prefer that the following people be in the room with me:

<input type="checkbox"/> Adoptive Parents	<input type="checkbox"/> Friends	<input type="checkbox"/> Family Members
---	----------------------------------	---

2. At the time of delivery, I would prefer that the following be in the room with me:

<input type="checkbox"/> Adoptive Parents	<input type="checkbox"/> Friends	<input type="checkbox"/> Family Members
---	----------------------------------	---

3. When the baby is born, I would like to:

<input type="checkbox"/> Hold the baby first	<input type="checkbox"/> Let the Adoptive family hold the baby first
<input type="checkbox"/> I prefer not to see the baby	

4. During postpartum, I prefer that the adoptive couple:

<input type="checkbox"/> Stay in my room with the baby	<input type="checkbox"/> Spend time in my room and in nursery
--	---

5. I would like to spend time with the baby:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

6. I understand I will meet with the hospital Social Worker to confirm that I am comfortable with my adoption plan and to complete the hospital discharge form:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

SIGNATURE: _____

DATE: _____