



Completing this form is voluntary. However, we encourage you to provide as much information as you can. You may choose to:

1. release information that will identify you to the birth child or their family;
2. provide only non-identifying information that will not identify you; or
3. both.

Each section of this form is designated as identifying or non-identifying. Please type or print in black or blue ink. Each birth parent/birth parent survivor who reports information must complete a separate form for each child placed for adoption. If you don't know or are unsure about an answer, leave it blank.

Identifying information will include names and contact information.

Non-identifying information does not include names and contact information but does include medical, social and educational information, etc.

Please check the appropriate choice below:

- I am providing family information for the first time. I am updating family information previously submitted.

Please indicate your relationship to the child for whom you are completing this information:

- Birth Mother Birth Father Birth Parent Survivor*

*Birth Parent Survivor includes the deceased birth parent's spouse, parent, sibling, child (birth, adoptive and stepchild), grandchild, aunt, uncle, children of aunts and uncles if no other relatives survive and children of grandchildren if no other relatives survive.

I. CHILD'S INFORMATION

CHILD'S CURRENT NAME (Last, First, Middle)		CHILD'S NAME RECORDED ON ORIGINAL BIRTH CERTIFICATE (Last, First, Middle)		
DATE OF BIRTH (MM/DD/YYYY)		GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PLACE OF BIRTH	COUNTY	CITY/MUNICIPALITY	STATE	HOSPITAL (if applicable)
LOCATION WHERE PARENTAL RIGHTS WERE TERMINATED (City/County, State)		DATE PARENTAL RIGHTS WERE TERMINATED (MM/DD/YYYY)		

AUTHORIZATION TO RELEASE IDENTIFYING INFORMATION

You may select as many or as few of the choices listed below as you wish. I agree to release **identifying** information to the individuals checked below:

- | | |
|---|--|
| <input type="checkbox"/> Birth child (when he or she turns 18) | <input type="checkbox"/> Birth child's descendants (if the birth child is deceased) |
| <input type="checkbox"/> Birth child's adoptive parents (if the birth child is under 18 or adjudicated incapacitated) | <input type="checkbox"/> Birth child's birth grandparents provided the birth child is at least 21 or I am adjudicated incapacitated or deceased. |
| <input type="checkbox"/> Birth child's legal guardian | <input type="checkbox"/> Birth child's birth siblings if both are 21. |

Even if you choose to release identifying information to the birth child, you may specify that you do or do not wish contact.

- I wish to have contact with the birth child. I do not wish to have contact with the birth child.

I understand that by my signature below, I am agreeing to the release of identifying information to the people checked above. I may change this consent at any time by updating this form or by submitting a Withdrawal of Authorization to Release Information Form.

SIGNATURE OF BIRTH PARENT/ BIRTH PARENT SURVIVOR		DATE	
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REGISTRATION INFORMATION

II. BIRTH MOTHER'S PERSONAL (IDENTIFYING) INFORMATION

BIRTH MOTHER'S NAME (Last, First, Middle)		PREVIOUS NAMES (Include maiden name, nicknames, and aliases. Last, First, Middle)	
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE

BIRTH MOTHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

HIGHEST GRADE LEVEL ACHIEVED	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
I WOULD DESCRIBE MYSELF AS:	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
MARITAL STATUS	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
CHILDREN	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	
RACE/ETHNICITY (Check all that apply)				
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White	<input type="checkbox"/> Other _____	Ethnicity Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	HAIR TYPE
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight
COMPLEXION			HANDEDNESS	
<input type="checkbox"/> Light	<input type="checkbox"/> Olive	<input type="checkbox"/> Medium	<input type="checkbox"/> Dark	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed

BIRTH MOTHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed

PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	FATHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	FATHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	FATHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	FATHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	FATHER'S NAME		



III. BIRTH FATHER'S PERSONAL (IDENTIFYING) INFORMATION

BIRTH FATHER'S NAME (Last, First, Middle)		PREVIOUS NAMES (Include nicknames and aliases. Last, First, Middle)	
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE

BIRTH FATHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

HIGHEST GRADE LEVEL ACHIEVED	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
I WOULD DESCRIBE MYSELF AS:	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
MARITAL STATUS	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
CHILDREN	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	

RACE/ETHNICITY (Check all that apply)

American Indian/Alaska Native Asian African American/Black Native Hawaiian/Pacific Islander

White Other _____ Ethnicity Hispanic: Yes No

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	HAIR TYPE
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight

COMPLEXION				HANDEDNESS	
<input type="checkbox"/> Light	<input type="checkbox"/> Olive	<input type="checkbox"/> Medium	<input type="checkbox"/> Dark	<input type="checkbox"/> Right-handed	<input type="checkbox"/> Left-handed

BIRTH FATHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed

PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		



IV. BIRTH PARENT SURVIVOR'S (IDENTIFYING) INFORMATION

NAME (Last, First, Middle)			
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE

V. PREGNANCY, BIRTH AND EARLY CHILDHOOD HISTORY (BIRTH MOTHER ONLY - NON-IDENTIFYING)

AGE AT FIRST MENSTRUAL PERIOD	IF APPLICABLE, AGE AT MENOPAUSE	NUMBER OF PREGNANCIES
NUMBER OF LIVE BIRTHS	NUMBER OF MISCARRIAGES	MULTIPLE BIRTHS
		<input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other: _____
HISTORY OF REPRODUCTIVE SYSTEM PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)		
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Fibroid Tumors (Benign)
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Other _____	<input type="checkbox"/> Ovarian Cysts (Benign)

THE QUESTIONS BELOW PERTAIN SPECIFICALLY TO THE PREGNANCY FOR THE CHILD IDENTIFIED IN SECTION I.

COMPLICATIONS DURING THIS PREGNANCY		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Toxemia	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Other _____	
ANY INJURY DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below.)
X-RAY PROCEDURES DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Month of Pregnancy _____)
If YES, purpose of X-Ray:		
DISEASES DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list below.)
DISEASE		TREATMENT
LENGTH OF PREGNANCY?		<input type="checkbox"/> Premature - Number of weeks early: _____ <input type="checkbox"/> Full-Term <input type="checkbox"/> Post-Term - Number of weeks late: _____
TOBACCO USE DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of cigarettes daily: _____)
ALCOHOL USE DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of drinks weekly: _____)
LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY		
DURATION OF LABOR		Hours: _____
TYPE OF DELIVERY		<input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Breech <input type="checkbox"/> Caesarean
COMPLICATIONS DURING DELIVERY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below)



VI. FAMILY MEDICAL HISTORY (NON-IDENTIFYING)

This section applies only to the birth family member who is completing this form and his or her blood relatives.

- Check SELF if medical condition applies to the BIRTH PARENT who is completing the form.
- Check FAMILY if medical condition applies to a blood relative of the birth parent.
 - When FAMILY is checked, complete the RELATIONSHIP TO BIRTH PARENT column.
 - Indicate if family member is a maternal (birth parent's mother's side) or a paternal (birth parent's father's side) relative.

MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT
ALLERGIES							
ENVIRONMENTAL				FOOD			
PLANT				DRUG/CHEMICAL			
ANIMAL							
OTHER (specify):							
EAR & EYE CONDITIONS							
CATARACTS				FAR-SIGHTED			
GLAUCOMA				ASTIGMATISM			
COLOR BLINDNESS							
BLINDNESS	Cause:	<input type="checkbox"/> Hereditary	<input type="checkbox"/> Non-hereditary	Type:	<input type="checkbox"/> Partial	<input type="checkbox"/> Total	
DEAFNESS	Cause:	<input type="checkbox"/> Hereditary	<input type="checkbox"/> Non-hereditary	Type:	<input type="checkbox"/> Partial	<input type="checkbox"/> Total	
OTHER (specify):							
BLOOD, HEART & CIRCULATORY CONDITIONS							
HEART ATTACK				HIGH BLOOD PRESSURE			
STROKE				ANEMIA			
HARDENING OF THE ARTERIES				HEMOPHILIA			
BLOOD CLOTS IN THE LEGS				SICKLE CELL ANEMIA			
OTHER (specify):							
BRAIN & NERVOUS SYSTEM CONDITIONS							
ALZHEIMER'S DISEASE				PARKINSON'S DISEASE			
MULTIPLE SCLEROSIS				MIGRAINE HEADACHES			
EPILEPSY & OTHER SEIZURE OR CONVULSIVE CONDITIONS				HUNTINGTON'S DISEASE			
CEREBRAL PALSY				TOURETTE'S SYNDROME			
OTHER (specify):							



MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT
HORMONAL DISORDERS							
DIABETES							
THYROID DISORDER			Specify: <input type="checkbox"/> Overactive thyroid <input type="checkbox"/> Underactive thyroid <input type="checkbox"/> Goiter <input type="checkbox"/> Iodine Deficiency				
PITUITARY GLAND DISORDER			Specify: <input type="checkbox"/> Excessive hormone <input type="checkbox"/> Reduced hormone <input type="checkbox"/> Growth hormone deficiency				
OTHER (specify):							
INTELLECTUAL & DEVELOPMENTAL CONDITIONS							
DOWN SYNDROME							
PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM							
MENTAL RETARDATION			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
SPEECH/COMMUNICATION DISORDERS			Cause: <input type="checkbox"/> Brain damage <input type="checkbox"/> Developmental delay <input type="checkbox"/> Structural abnormality (mouth)				
LEARNING DISORDERS			Specify: <input type="checkbox"/> Dyslexia (reading) <input type="checkbox"/> Dysgraphia (writing) <input type="checkbox"/> Minimal brain damage				
OTHER (specify):							
MENTAL & BEHAVIORAL CONDITIONS							
SCHIZOPHRENIA				ATTENTION DEFICIT DISORDER (ADD)			
ANXIETY DISORDER				ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)			
MAJOR DEPRESSIVE DISORDER				DRUG ABUSE			
BIPOLAR DISORDER (MANIC DEPRESSIVE)				POST-TRAUMATIC STRESS DISORDER			
ALCOHOLISM				ANOREXIA NERVOSA			
OBSESSIVE COMPULSIVE DISORDER							
OTHER (specify):							
GASTROINTESTINAL URINARY SYSTEM CONDITIONS							
KIDNEY DISEASE			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
LIVER DYSFUNCTION			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
GALL BLADDER DISORDER			<input type="checkbox"/> Gall stones <input type="checkbox"/> Infection <input type="checkbox"/> Tumor				
ULCERS							
DIVERTICULITIS							
ULCERATIVE COLITIS/CROHN'S DISEASE							
OTHER (specify):							



MEDICAL CONDITION (check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
CANCER							
BLOOD (Leukemia)				BRAIN			
COLON				HODGKIN'S DISEASE			
PROSTATE				PANCREAS			
UTERINE				LIVER			
BREAST				OVARIAN			
LUNG				CERVICAL			
SKIN				STOMACH			
BONE				THROAT			
OTHER (specify):							
GENETIC CONDITIONS							
MUSCULAR DYSTROPHY				MARFAN'S SYNDROME			
SPINA BIFIDA				TAY-SACHS DISEASE			
CLUB FOOT				HARE LIP			
DWARFISM				CLEFT PALATE			
CYSTIC FIBROSIS							
OTHER (specify):							
OTHER CONDITIONS							
HIGH CHOLESTEROL				OBESITY			
ARTHRITIS				LUPUS			
ASTHMA							
EXPOSURE TO CHEMICALS & TOXIC MATERIALS (specify):							
OTHER (specify):							

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (section 9404 of the Pennsylvania Crimes Code). Further, I understand that it is my responsibility to notify the registry of any change in my address or submitted information.

SIGNATURE		DATE	
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