Ohala' Adoptions

Biological Parents Introductory Information

The information requested in the following pages is necessary to assist us in finding the best adoptive family for you. Please take your time and complete this form. If you would prefer, you may have one of our directors help you complete this form, instead of on your own. The end of this document is a release of information that must be completed for Ohala' Adoptions to move forward with your adoption plan.

Today's Date: _____

Due Date: _____or weeks along _____

Full Name (First, Middle, Last, & Maiden)_____

Current Physical Address _____

*include a simple map on the back of this page if needed.

Social Security Number _____

Home Telephone # _____ Cell # _____

Work # _____

May we contact you at: Leave identifying info 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 plan? 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 Asian Islander – specify _____ Other

Marital Status: Single Married Separated Divorced

United States Citizen Yes No If no, passport/visa # _____

Guam ID _____

What will be your age when your child is born? _____

What is your height? _____

What was your weight before 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 adoption worker will talk more about this when you meet and together find a family profile to meet your wishes.

Marital Status of the adoptive family:

Married Single Same sex couples No preference

Preferred Race of the adoptive family, if any_____

Preferred religion of the adoptive family , if any_____

Have you considered other options including family member or friend to adopt? Yes No

Has any family member or friend expressed an interest in adopting your child? Yes No

Have any of the birth father's family 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

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

Please circle: Phone calls Texts Contact ONLY through Ohala' Adoptions

Do you want the adoptive parent(s) 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

Explain what led 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, give information.

_____

_____

_____

Have you ever been reported for child abuse or neglect? Yes No

Are you part of a Native American or Alaskan Native tribe? Yes No

If yes, please indicate the location, your registration or ID number, and all 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 _____ Race/ Island of origin_____

Your Father's Name _____ Race/ Island of origin_____

Your brother/ Sister's Names

_____

_____

Current Pregnancy Information

Is this your first pregnancy? Yes NoIf no, how many pregnancies?

Please indicate what occurred with your prior pregnancies. Carried to full term Abortion Miscarriage Vaginal Birth C-Section Birth

Have you been involved in any accidents during this pregnancy? Yes No If yes, explain __

_____

_____

Have there been any complications during this pregnancy? Yes No If yes, explain

_____

Have you been exposed to any of the following during your pregnancy? (Check all that apply.)

X-ray EKG Radiation None

History of Previous Children

Name	Date of Birth	Birth Gender	Birth Weight	Race	Half or Full sibling	Length of pregnancy
		M F				
		M F				
		M F				
		M F				

Birth Father Information

Your adoption case 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 case worker can send him social and medical history forms to complete.

What if the name of the father? _____

What is his date of birth and/or age? _____

What is the phone number of the birth father? _____

What was the approximate date of the conception? _____

Are you certain the identified birthfather is the biological father? Yes No

Has the identified birth father acknowledged that he is the biological father? Yes No

What is the race of the birth father, and/or island of origin?_____

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? Yes No

Do you live together now? 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, please explain._____

Has he given or offered any support financially or emotionally during this pregnancy? Yes No

Do the parents of the birth father know of the adoption plans? Yes No

Do the parents of the birth father agree with the adoption plans? Yes No

Prenatal Care and Hospital Information

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

Have you received prenatal care? Yes No

If yes, in what month did you start receiving care? _____

Does your Doctor/ Clinic know of your adoption plans? Yes No

From what Doctor or Clinic have you received prenatal care?_____

Address: _____

Phone: _____ Doctor _____

What is the name of the hospital or clinic where you will be delivering or midwife assisting you?

_____ Address _____

Phone _____ I haven't decided yet

Medicaid Information:

Do you have state issued Medicaid? Yes No

If yes, Medicaid # _____ If not, are you willing to apply? Yes No

Medicaid worker's name and phone # _____

Insurance Information:

Private medical insurance Yes No

If yes, what carrier? (Moylan's, Calvo's, etc.) _____

Name:_____ Phone: _____

Address: _____

Policy Number : _____

Percentage of bills covered? _____

Health History of Biological Mother

Place and "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 family members have any of these conditions. If a condition resulted in the death of a family member, please indicate "deceased" next to their name in the Other Family Members section. On the bottom of each section there is room for you to explain further anything needing clarification. Please fill out as accurately as possible. We have wonderful, loving families willing to accept children that have any medical conditions, but detailed information is very helpful.

Infectious Diseases: Nothing applies to me in this section.

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

Oncology: Nothing applies to me in this section

Cancer (please list type)	Self	Other Family Member(s) if applicable, who?

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		
SIDS (Sudden Infant Death)		
Other		

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

Medical Condition	Age of onset	Medication/Treatment	Other Information

Women' 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 sections above, please explain in further detail below

Medical Condition	Age of onset	Medication/Treatment -Other information

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 Tract 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 sections above, please explain in further detail below.

Medical Condition	Age of onset	Medication/ Treatment	Other Information

Behavioral: Nothing applies to me in this section.

	Self	Other Family Member(s) If applicable, who?
Learning Disability		
ADHA/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 sections above, please explain in further detail below.

Medical Condition	Age of onset	Medication/ Treatment	Other Information

Allergies: Nothing applies to me in this section.

Allergic to?	Reaction? (rash/hives,etc.)	Self	Other Family Members

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

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

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

_____

Confidential Drug/Alcohol Usage

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

Substance	Used occasionally (1-5 times) during pregnancy	Used daily or almost 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-Convulsant				
Other				
Other				

I confirm the information I have supplied in the Biological Parent Social and Medical History is true and accurate. 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.

I understand this information will be shared with the adoptive parents in a confidential manner without disclosing identifying information. It may be shared with the medical professionals at the medical facility where my prenatal care and delivery will take place, if applicable. I also understand that the adoptive family and other parties may rely on this information to decide whether or not to move forward with any anticipated adoption plans.

I hereby waive any claim of privilege and agree that the information 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, if needed.

I understand that a birth mother will not receive compensation for creating and/or finalizing an adoption plan or adoption. I further understand that I am entering into a plan that places my child (or children) for adoption and any false statements may be viewed as perjury and in violation of penal laws of Guam and may subject me to criminal and/or civil penalties.

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

How did you hear about our agency?
Local Paper Clinic/ Hospital FB/ Instagram
Friend/ Family Social Worker TV/ Radio