

BIRTH PARENT INFORMATION UPDATE

This form gives you an opportunity to update health and social information about yourself and your family members. This new information will be placed in the agency file, and whenever possible, will be shared with the adoptee, or the adoptive family if the child is under age 18. Adoptees 18 and older may receive the information directly upon request.

PLEASE READ CAREFULLY, FILL OUT FORM AND RETURN TO:

Lutheran Social Services of South Dakota
Attn: Post-Legal Adoption Services
621 East Presentation Street
Sioux Falls, SD 57104

Add any additional biographical statements if you wish, or anything else you may want to share about your family history. Photos may be included.
This information will be a priceless gift to the adoptee.



Strengthening Individuals,
Families & Communities

UPDATED BACKGROUND INFORMATION

I am Birthmother Birthfather Other _____

IDENTIFYING INFORMATION

Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Email: _____ Place of Birth: _____

Spouse: _____ Religion: _____

If married, does your spouse know about the child who was placed for adoption? Yes No

Were you adopted? Yes No If yes, do you know birth family/history? Yes No

PHYSICAL DESCRIPTION

Height: _____ Weight: _____ Eye Color: _____ Hair Color & Texture: _____

Complexion: _____ Distinguishing Features: _____

Nationality/Race: _____ If Native American, what tribe? _____

Describe your personality: _____

EDUCATION

Names of schools you attended: _____

Last grade or degree completed: _____

Field of study: _____

Extra Curricular Activities: _____

Present Hobbies & Interests: _____

EMPLOYMENT HISTORY

Current Occupation: _____

Place of Employment: _____

Previous Occupations: _____

Military Service/Branch: _____

HEALTH

Present general health: _____

Childhood diseases: _____

Major illnesses/surgery: _____

Glasses/contacts (if yes, for what condition): _____

FAMILY HISTORY

Were you or any members of your immediate family placed for adoption? Yes No

If yes, who: _____

Birthparent's Genetic Father

Name: _____

Address: _____

DOB/Age: _____

If deceased, age at/cause of death: _____

Any serious health issues: _____

Height: _____ Weight: _____

Hair Color/Texture: _____ Eye Color: _____

Education: _____

Hobbies and Talents: _____

Occupation: _____

Place of Employment: _____

Nationality: _____

Religion: _____

Does your father know about the child who was placed for adoption? Yes No

Birthparent's Brothers and Sisters

Name: _____

Address: _____

DOB/Age: _____

Spouse: _____

If deceased, age at/cause of death: _____

Height: _____ Weight: _____

Hair Color/Texture: _____ Eye Color: _____

Ages/health of children: _____

Hobbies and Talents: _____

Occupation: _____

Any serious health issues: _____

Does this sibling know about the child who was placed for adoption? Yes No

Birthparent's Genetic Mother

Does your mother know about the child who was placed for adoption? Yes No

(Attach another page if needed)

Does this sibling know about the child who was placed for adoption? Yes No

Any additional information: _____

Birthparent's Paternal Grandfather

Name: _____
Address: _____
DOB/Age: _____
If deceased, age at/cause of death: _____
Any serious health issues: _____
Height: _____ Weight: _____
Hair Color/Texture: _____ Eye Color: _____
Education: _____
Hobbies and Talents: _____
Occupation: _____
Place of Employment: _____
Nationality: _____
Religion: _____
Does this grandparent know about the child who was placed for adoption? Yes No

Birthparent's Paternal Grandmother

Does this grandparent know about the child who was placed for adoption? Yes No

Birthparent's Maternal Grandfather

Name: _____
Address: _____
DOB/Age: _____
If deceased, age at/cause of death: _____
Any serious health issues: _____
Height: _____ Weight: _____
Hair Color/Texture: _____ Eye Color: _____
Education: _____
Hobbies and Talents: _____
Occupation: _____
Place of Employment: _____
Nationality: _____
Religion: _____
Does this grandparent know about the child who was placed for adoption? Yes No

Birthparent's Maternal Grandmother

Does this grandparent know about the child who was placed for adoption? Yes No

MEDICAL HISTORY

Please indicate by checking YES or NO if you or any genetic relative (ie. Your mother, father, siblings, grandparents, aunts, uncles or other children born to you) ever had or now have the medical conditions listed. If so, complete the comment section, and include the part of the body affected, severity, age at onset, treatment, known cause, and medication.

Club Foot: No Self Other Relative _____
Comments: _____

Cleft lip or palate: No Self Other Relative _____
Comments: _____

Congenital Heart Defect: No Self Other Relative _____
Comments: _____

Malformations: No Self Other Relative _____
Comments: _____

Muscular Dystrophy: No Self Other Relative _____
Comments: _____

Multiple Sclerosis: No Self Other Relative _____
Comments: _____

Cerebral Palsy: No Self Other Relative _____
Comments: _____

Paralysis: No Self Other Relative _____
Comments: _____

Epilepsy or Seizures: No Self Other Relative _____
Comments: _____

Blindness, Glaucoma, or Cataracts: No Self Other Relative _____
Comments: _____

Hearing Impairment: No Self Other Relative _____
Comments: _____

Speech problems: No Self Other Relative _____
Comments: _____

Learning Disability: No Self Other Relative _____
Comments: _____

Down's Syndrome: No Self Other Relative _____
Comments: _____

Chromosome Abnormality: No Self Other Relative _____
Comments: _____

Hydrocephalus: No Self Other Relative _____
Comments: _____

Microcephaly: No Self Other Relative _____
Comments: _____

Spina Bifida: No Self Other Relative _____
Comments: _____

Other brain or nervous system disorders: No Self Other Relative _____
Comments: _____

Diabetes: No Self Other Relative _____
Comments: _____

Scoliosis: No Self Other Relative _____
Comments: _____

Dwarfism: No Self Other Relative _____
Comments: _____

Arthritis: No Self Other Relative _____
Comments: _____

Thyroid Disorder: No Self Other Relative _____
Comments: _____

Hormone Disorder: No Self Other Relative _____
Comments: _____

Eczema: No Self Other Relative _____
Comments: _____

Asthma: No Self Other Relative _____
Comments: _____

Allergies: No Self Other Relative _____
Comments: _____

- Hemophilia: No Self Other Relative _____
Comments: _____
- Sickle Cell: No Self Other Relative _____
Comments: _____
- Blood Disorders: No Self Other Relative _____
Comments: _____
- Hypertension: No Self Other Relative _____
Comments: _____
- Stroke: No Self Other Relative _____
Comments: _____
- Heart Disease: No Self Other Relative _____
Comments: _____
- Cancer: No Self Other Relative _____
Comments: _____
- Alzheimer's: No Self Other Relative _____
Comments: _____
- Neurofibromatosis: No Self Other Relative _____
Comments: _____
- Crohn's Disease or other digestive health issues: No Self Other Relative _____
Comments: _____
- Tay Sachs Disease: No Self Other Relative _____
Comments: _____
- Dental Problems: No Self Other Relative _____
Comments: _____
- Cystic Fibrosis: No Self Other Relative _____
Comments: _____
- Huntington's Disease: No Self Other Relative _____
Comments: _____
- Infertility: No Self Other Relative _____
Comments: _____
- Miscarriages: No Self Other Relative _____
Comments: _____
- Stillbirths: No Self Other Relative _____
Comments: _____
- SIDS: No Self Other Relative _____
Comments: _____
- Immunodeficiency: No Self Other Relative _____
Comments: _____
- Attention Deficit Disorder: No Self Other Relative _____
Comments: _____
- Schizophrenia: No Self Other Relative _____
Comments: _____
- Personality Disorders: No Self Other Relative _____
Comments: _____
- Bipolar Disorder: No Self Other Relative _____
Comments: _____
- Depression: No Self Other Relative _____
Comments: _____

Chemical Dependency: No Self Other Relative _____

Comments: _____

Any additional comments/other conditions that run in your family: _____

Other Children Born to You

(Attach another page if needed)

Name: _____

Address: _____

DOB/Age: _____

Spouse: _____

If deceased, age at/cause of death: _____

Height: _____ Weight: _____

Hair Color/Texture: _____ Eye Color: _____

Any health issues: _____

Hobbies and Talents: _____

Education: _____

Occupation: _____

Place of Employment: _____

Does this sibling know about the child who was placed for adoption? Yes No

Does this sibling know about the child who was placed for adoption? Yes No

INFORMATION ABOUT OTHER BIRTHPARENT *(if known)*

Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Email: _____ Place of Birth: _____

*Spouse: _____ Religion: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color & Texture: _____

Complexion: _____ Distinguishing Features: _____

Nationality/Race: _____ If American Indian, what tribe? _____

Any serious health issues: _____

Describe his/her personality: _____

Names of schools attended: _____

Last grade or degree completed: _____

Field of study: _____

Extra Curricular Activities: _____

Present Hobbies & Interests: _____

Current Occupation: _____

Place of Employment: _____

Previous Occupations: _____

Military Service/Branch: _____

Was he/she adopted? Yes No If yes, do you know their birth family/history? Yes No

*If married, does spouse know about the child who was placed for adoption? Yes No

Your relationship with other birthparent/comments *(then and/or now)*: _____

INFORMATION ABOUT THE ADOPTEE (if known)

Name given at birth: _____ Date/Place of Birth: _____

Weight/length at birth: _____ Birthparent's age at birth: _____

Weeks of gestation: _____

Medications taken during pregnancy: _____

Alcohol/tobacco/drug use during pregnancy: _____

Complications during pregnancy/labor & delivery: _____

Any additional information (ie. Apgar, blood type, newborn screening tests if known): _____

Indicate your present feelings about the adoption plan that was made for this child: _____

What information did the agency share with you about the adoptive family: _____

Is there any information you do not want shared with the adoptee or adoptive family: _____

I understand that everything, other than what I have state in the last question above, may be shared with the adoptee or adoptive family.

(Signature)

(Date)

Subscribed and sworn to before me this _____ day of _____, in the year _____, in the State of South Dakota in the County of _____.

Signature of Notary Public

My Commission Expires

NOTORIAL SEAL: