

## Adoptive Family Preference Checklist

Husband's Name \_\_\_\_\_ Wife's Name \_\_\_\_\_

**INSTRUCTIONS:** This checklist is to help us know better your specific desire, preferences and interests in a child to be adopted. Please know that there is no right or wrong answers.

<b>Sex of child:</b> <input type="checkbox"/> Either <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Age of child:</b> <input type="checkbox"/> under 3 months <input type="checkbox"/> <-1 <input type="checkbox"/> 1-2 <input type="checkbox"/> 2-4	Would you accept a child with an unknown father? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you accept a child not yet legally free for adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you accept a sibling group? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you accept twins? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--	---	--

**CONDITIONS:** Please indicate your willingness to accept the following conditions in a child or a child's birth parents. Check all that apply.

Lifestyle/Medical/Mental Health	Child None Mild Mod Sev	Birth Mother None Mild Mod Sev	Birth Father None Mild Mod Sev	RACIAL/ETHNIC BACKGROUND: Please indicate your preference for the following backgrounds in a child. Check <u>all</u> that apply.																																				
<b>Medical Conditions</b>				<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Full</td> <td style="text-align: center;">Half</td> <td style="text-align: center;">None</td> </tr> <tr> <td>African American</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Asian American</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Caucasian</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hispanic</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Middle Eastern</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Native American</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Polynesian</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Full	Half	None	African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asian American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caucasian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Middle Eastern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polynesian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Full	Half	None																																					
African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Asian American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Caucasian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Middle Eastern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Polynesian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Disease/defect of major organ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Hemophilia/Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
<b>Mental/Emotional</b>																																								
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Tourette's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Obsessive Compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
<b>Substance Abuse</b>																																								
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Cigarettes/tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
<b>Sexually Trans. Disease</b>																																								
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Other STDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
<b>Other Special Needs</b>																																								
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Downs Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Emotional/attachment issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Physical deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Physical neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Premature birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
<b>Other please specify</b>																																								

**SHARING OF INFORMATION:**  
Please indicate your openness to the following types of contact with birth parents by checking all that apply. **NOTE:** Prior to placement and finalization all correspondence will be reviewed by the agency. Following finalization correspondence will be forwarded without review. The AA is responsible for all postage.

**Prior to Placement** (after you have been selected)  
 Letters  
 Appropriate gifts  
 Photographs of you  
 Face to face meeting (agency assisted)  
 Phone call (agency assisted)

**Between Placement and Finalization**  
 Letters  
 Gifts as desired  
 Photographs of child and you  
 E-mails

**After Finalization**  
 E-mails  
 Pictures  
 Identifying Information  
 Phone Calls  
 In-person Visits

**COMMENTS:** Please clarify as needed any of your preferences noted above. (use the back if needed)

**SIGNATURES:**

Husband \_\_\_\_\_ Wife \_\_\_\_\_ Date \_\_\_\_\_