Instructions on completing the Birth Parent Information Packet

As the biological parent, you are able to submit the documents contained in this packet as additional information in the event the adoptee or any lineal descendants request the adoption file. This packet includes the Contact Preference Form, Social/Medical History Form and an Application for the Release of the Adopted Name. Below you will find you will find detailed instructions on completing and submitting the forms.

1. Contact Preference for the Birth Parent – This form will allow the biological parent to state how they would like to be contacted if the adoption file is released. You can choose direct contact, contact through an intermediary or no contact at all. This form is advisory only and not enforceable. It does not ensure that contact will or will not be made. The Social/Medical History Form is not required but is encouraged to be completed.

2. Social/Medical History Form – This form will allow the biological parents to update any social and medical information they wish for the adoptee or any lineal descendants to be aware of. This form collects information for both the birth mother and birth father; only complete the section that applies to your biological status. Do not complete the other parent's section.

3. Application for Release of Adopted Name – This form will allow the biological parents to ask for the Biological Child's Adopted Name. Please be advised that the adopted name will only be given if the adoptee has completed the Authorization of Release of Adopted Name.

This packet only applies to the biological parents of an adoptee. No other persons by biological relation can submit this packet.

This office only has adoption files and Birth Records for persons whose birth occurred in the State of Ohio. If the birth of the biological child occurred in another state please contact that state for more information.

In order for your packet to be accepted, it must be returned with two forms of identification.(Two items of identification must include a motor vehicle driver's or commercial driver's license, a state issued identification card, a marriage application, a social security card, a credit card, a military identification card, or an employee identification card.)

Please make sure that any forms submitted are completed with as much information as possible and the print is legible.

Please return the packet to:

Ohio Department of Health
Attn: Special Registration
P. O. Box 15098
Columbus, OH 43215

Ohio Department of Job and Family Services

CONTACT PREFERENCE FOR THE BIRTH PARENT(S) OF ADOPTED CHILDREN

This form enables a birth parent of an adopted person to state their preference regarding contact with the adopted person or their lineal descendant. Provide as much information as possible in order for the form to be matched to the correct adoptive record. **Two forms of identification must be submitted with this form.**

Name: _____

Your relationship to the adopted child: Birth Mother ____ Birth Father ____ Date: _____

Adopted Person's Information as Listed on the Original Birth Record

Name at Birth _____ Male _____ Female _____

Date of Birth _____ Place of Birth (city, county) _____

Mother's Name as listed on the Original Birth Record _____

Father's Name as listed on the Original Birth Record _____

Birth Parent's Contact Preference

Please indicate your preference regarding contact with the adopted person or their lineal descendant, in the event the adoption file is released. Please check one box below and complete the corresponding information.

☐ I would like to be contacted directly by the adopted person or their lineal descendant.
Name _____
Address _____
Phone (___) _____ Email/Other _____

☐ I would prefer to be contacted only through an intermediary.
Name _____
Address _____
Phone (___) _____ Email/Other _____

☐ I would prefer not to be contacted at this time by the adopted person or their lineal descendant.

Social and Medical History

Please consider completing the attached social and medical history form so that the adopted person or their lineal descendant may have current social and medical information. Be aware that the social and medical history form may be inspected by the adoptive parent while the child is a minor, and an adopted person once they are an adult. Those individuals may request to be notified if the form is ever revised or expanded by contacting the court that finalized the adoption. If they are not aware which court finalized the adoption, they may contact the Department of Health for assistance. At any time, this information may be updated by the birth parent. Please check the appropriate box below regarding your social and medical history.

☐ I am aware that a social and medical history form was completed at the time of the adoption.
☐ I completed a social and medical history form after the adoption took place.
☐ I updated the social and medical history form after the adoption took place.
☐ I have completed the attached social and medical history form and am submitting it with this form.

Please note: this form is advisory only and not enforceable. It does not ensure contact will or will not be made. You may change your mind at any time regarding your contact preference, simply complete another JFS 01684 and submit it to the Department of Health. If you would like to provide any additional information to the adopted person or their lineal descendant, please provide that information in the space below or on back of this form.

_____
_____
_____

Ohio Department of Job and Family Services

SOCIAL AND MEDICAL HISTORY

(Completion of the entire form is mandated by ORC 3107.09)

CHILD'S INFORMATION

Name of Child	Date of Birth *(mm/dd/yyyy)*	Date Form Completed *(mm/dd/yyyy)*

You are being asked to provide family history information at a time that we know is difficult for you, however, this information may be important at some point in providing medical care for your child. There are many medical conditions that can run in families. We are trying to obtain a completed medical history because your child may need this information in the future. Please answer the questions as best as you can. If you have any questions about how to answer anything, please ask your worker for help. Each birth parent should complete a social and medical history form.

HISTORY OF BIOLOGICAL PARENTS

Sometimes children are born to parents who are related by blood. These children may have a higher chance of having health problems. For this reason we need to know if there is any blood relationship between the birth parents. If the child's parents are related by blood, please check the two (2) boxes that describe the relationship. (For example, the child's mother married her uncle or half brother)

☐ Father	☐ Mother	☐ Daughter
☐ Brother	☐ Sister	☐ Son
☐ Cousin	☐ Uncle	☐ Aunt
☐ Half Sister	☐ Niece	☐ Other, please specify _____

MARITAL HISTORY OF BIOLOGICAL PARENTS

The biological parents were

☐ Never Married ☐ Married Now ☐ Divorced ☐ Widowed

DELIVERY AND BIRTH INFORMATION OF THE CHILD

How long was the birth mother in labor?	Was the Delivery ☐ Vaginal ☐ Cesarean
If Cesarean, why?	
Were there any problems during this delivery? ☐ Yes ☐ No ☐ Don't Know	
If "Yes," please explain	
The baby was born ☐ Breech ☐ Head First ☐ Don't Know	
Was there a heart murmur at birth? ☐ Yes ☐ No ☐ Don't Know	
If "Yes," please explain	
Were any problems noted AT birth? ☐ Yes ☐ No ☐ Don't Know	
If "Yes," please explain	
Were any problems noted AFTER birth? ☐ Yes ☐ No ☐ Don't Know	

If "Yes," please explain

BIRTH AND MEDICAL HISTORY

Sex
☐ Male ☐ Female

Date of Birth *(mm/dd/yyyy)*

Was the child born
☐ At Term ☐ Premature ☐ Post Mature

If Premature, how many weeks

If Post Mature, how many weeks

Child's Weight *(at birth)*

Child's Birth Length *(in inches)*

Child's Blood Type
☐ A ☐ B ☐ AB ☐ O

Child's RH
☐ Positive ☐ Negative ☐ Don't Know

APGAR Score
☐ One Minute ☐ Five Minutes ☐ Don't Know

Were any of the following Newborn Screening Tests Positive?

PKU *(phenylketonuria)*	☐ Yes	☐ No	☐ Don't Know
Galactosemia	☐ Yes	☐ No	☐ Don't Know
Hypothyroidism	☐ Yes	☐ No	☐ Don't Know
Sickle Cell Disease	☐ Yes	☐ No	☐ Don't Know
Other *(specify)*	☐ Yes	☐ No	☐ Don't Know

In what month of your pregnancy did you first see a health care worker?

☐ One Month	☐ Two Months	☐ Three Months
☐ Four Months	☐ Five Months	☐ Six Months
☐ Seven Months	☐ Eight Months	☐ Nine Months

Did you, or do you have, or were you exposed to any of the following during your pregnancy?

	Yes	No	Don't Know	What Month in Pregnancy?	If Yes, Specify Diagnosis, Site, or Kind
Fever *(101 degrees or over)*	☐	☐	☐		
Infection	☐	☐	☐		
Rashes	☐	☐	☐		
X-Rays/Radiation	☐	☐	☐		
Chemicals	☐	☐	☐		
Toxic/Hazardous Waste	☐	☐	☐		
Sexually Transmitted Disease	☐	☐	☐		
HIV/AIDS	☐	☐	☐		
Diabetes	☐	☐	☐		
Measles *(red/rubella)*	☐	☐	☐		
Mumps/Chicken Pox	☐	☐	☐		
High Blood Pressure	☐	☐	☐		
Toxemia	☐	☐	☐		
Domestic Abuse	☐	☐	☐		

BIRTH AND MEDICAL HISTORY

Did you take any of the following during your pregnancy? If, Yes, how much a week did you take?

	Yes	No	Don't Know	What Month in Pregnancy	How Much per Week
Alcohol (include beer/wine)	☐	☐	☐		
Caffeine	☐	☐	☐		
Cigarettes	☐	☐	☐		
☐ Cocaine / ☐ Crack *(check)*	☐	☐	☐		
☐ Heroin / ☐ Methadone *(check)*	☐	☐	☐		
☐ LSD / ☐ Acid *(check)*	☐	☐	☐		
Marijuana	☐	☐	☐		
Amphetamines (Uppers)	☐	☐	☐		
Barbiturates *(Downers)*	☐	☐	☐		
Others *(Specify)*	☐	☐	☐		
Other *(Specify)*	☐	☐	☐		

For the following medications, please list the names of the medications, if known.

	Yes	No	Don't Know	What Month In Pregnancy	How Much Per Week
Prescription Drug	☐	☐	☐		
Over the Counter Medication	☐	☐	☐		
Seizure Medication	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER

Mother's Age	Year of Birth

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

General Physical Description *(i.e., hair color, eye color, height)*

Highest grade in school she completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College/University

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduated

Where you ever in special education classes? *(classes designed to help in learning)* ☐ Yes ☐ No

List awards, honors, and/or scholarships in high school

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Actively participated in school sponsored events, such as

Plans for further education and/or vocational goal, include

Other educational comments

Are you currently employed? ☐ Yes ☐ No

Current Employment *(type of job)*

Previous Employer *(type of job)*

Religious Affiliation

Do you have a preference about the religious affiliation for you child? ☐ Yes ☐ No

If Yes, specify

Are you adopted? ☐ Yes ☐ No ☐ Don't Know

Have you had any major illnesses? ☐ Yes ☐ No

If Yes, explain

Do you have or have you had any mental illness? ☐ Yes ☐ No

If Yes explain and tell about the treatment

Have you ever been told you have a genetic/inherited disease? ☐ Yes ☐ No

If Yes, please explain?

Have you ever been told you are a carrier of a genetic/inherited disease? ☐ Yes ☐ No

If Yes, what disease?

Describe any other children you have *(i.e., the children's brother and sisters)*: List in order of birth and the children who may have died. If a child died, please indicate age at death and the cause of death.

Relationship	Date of Birth	Health/Medical Problems

Have you ever had any miscarriages? ☐ Yes ☐ No

If Yes, how many?

How many living brothers do you have?

Did you have any brothers who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

How many living sister do you have?

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Did you have any sisters who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

Do any of your brothers or sisters have a different father or mother?

If Yes, please indicate which brother or sister and which parent was different from yours

Birth Mother's Parents

Mother's year of birth

Has she had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If she is dead: cause of death and age

Highest grade in school she completed *(check one)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did she receive special education? ☐ Yes ☐ No ☐ Don't Know

Father's year of birth

Has he had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If he is dead: cause of death and age

Highest grade in school he completed *(check one)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did he receive special education? ☐ Yes ☐ No ☐ Don't Know

Birth Mother's Grandparents

Birth Mother's Maternal Grandmother

Has she had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Birth Mother's Maternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Birth Mother's Paternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Birth Mother's Paternal Grandfather

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER

Genetic Medical History: Indicate by checking "YES" or "NO" if you or any blood relative (i.e. Your parents, grandparents, aunts, uncles, brothers, sisters, nieces, and nephews) ever had or Now have any of the medical conditions listed. Include only relatives who are your blood relatives (omitting relatives only by marriage or adoption, but including half-brothers and half-sisters). Indicate all relatives in terms of their relationship to you.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
1. Blindness or other Visual Problems *(i.e. Cataracts)*	☐	☐	☐	☐	
2. Hearing Impaired Difficulties/Unusual shape or ear missing	☐	☐	☐	☐	
3. Speech Problems	☐	☐	☐	☐	
4. Dental Problems *(i.e., missing tooth or extra tooth)*	☐	☐	☐	☐	
5. Cleft Lip *(harelip)*	☐	☐	☐	☐	
6. Cleft Palate	☐	☐	☐	☐	
7. Learning Disability or Slow Learner	☐	☐	☐	☐	
8. Mental Retardation	☐	☐	☐	☐	
9. Attention Deficit Disorder and/or Hyperactivity	☐	☐	☐	☐	
10. Down Syndrome	☐	☐	☐	☐	
11. Other Chromosome Abnormality *(specify)*	☐	☐	☐	☐	
12. Mental Illness *(e.g. manic depression,,schizophrenia, nervous breakdown)*	☐	☐	☐	☐	
13. Hydrocephalus *(water on the brain)*	☐	☐	☐	☐	
14. Microcephaly *(small head)*	☐	☐	☐	☐	
15. Patches of Hair of Different Color	☐	☐	☐	☐	
16. Patches of Skin of Different Color	☐	☐	☐	☐	
17. Birthmarks *(i.e., unusual shape, size or number)*	☐	☐	☐	☐	
18. Skin Problems *(i.e., severe eczema, acne)*	☐	☐	☐	☐	
19. Bleeding Problems or Hemophilia	☐	☐	☐	☐	
20. Sickle Cell Disease	☐	☐	☐	☐	
21. Thalassemia *(inherited anemia)*	☐	☐	☐	☐	
22. High Blood Pressure *(hypertenston)*	☐	☐	☐	☐	
23. Stroke	☐	☐	☐	☐	
24. Heart Disease before age 50 *(Coronary)*	☐	☐	☐	☐	
25. Born with Heart Defect *(i.e., whole in the heart)*	☐	☐	☐	☐	
26. Born with Open Spine *(Spina Befida)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
27. Born with Missing Brain *(anencephaly)*	☐	☐	☐	☐	
28. Born with Hip Problems *(dislocated hips)*	☐	☐	☐	☐	
29. Dwarfism or Short Statue	☐	☐	☐	☐	
30. Spinal Curvature *(Scoliosis)*	☐	☐	☐	☐	
31. Unusually Formed Bones or Many Broken Bones	☐	☐	☐	☐	
32. Unusually Formed Hands *(i.e., extra, missing, webbed fingers)*	☐	☐	☐	☐	
33. Unusually Formed Feet *(example; extra, missing, webbed toes)*	☐	☐	☐	☐	
34. Club Foot	☐	☐	☐	☐	
35. Other Birth Defects *(Not listed, please specify)*	☐	☐	☐	☐	
36. Arthritis	☐	☐	☐	☐	
37. Muscular Dystrophy	☐	☐	☐	☐	
38. Muscle Weakness	☐	☐	☐	☐	
39. Loss of Muscle Control	☐	☐	☐	☐	
40. Pyloric SteNosis *(projectile vomiting)*	☐	☐	☐	☐	
41. Breast Cancer	☐	☐	☐	☐	
42. Colon Cancer	☐	☐	☐	☐	
43. Ovarian Cancer	☐	☐	☐	☐	
44. Other Cancers *(type, site)*	☐	☐	☐	☐	
45. Cystic Fibrosis	☐	☐	☐	☐	
46. Alzheimer Disease	☐	☐	☐	☐	
47. Huntington Disease	☐	☐	☐	☐	
48. Neurofibromatosis *(benign tumor)*	☐	☐	☐	☐	
49. Multiple Sclerosis	☐	☐	☐	☐	
50. Tay Sachs Disease	☐	☐	☐	☐	
51. Cerebral Palsy	☐	☐	☐	☐	
52. Seizures, Convulsions, Epilepsy	☐	☐	☐	☐	
53. Childhood Diabetes	☐	☐	☐	☐	
54. Adult Diabetes *(insulin active or over active)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
55. Thyroid Disorder *(under active or over active)*	☐	☐	☐	☐	
56. Kidney Problems	☐	☐	☐	☐	
57. Respiratory or Breathing Problems	☐	☐	☐	☐	
58. Asthma	☐	☐	☐	☐	
59. Allergies/Hay Fever *(pollen)*	☐	☐	☐	☐	
60. Allergies Food *(specify)*	☐	☐	☐	☐	
61. Allergies Medicine *(specify)*	☐	☐	☐	☐	
62. Chemical Dependency *(alcohol)*	☐	☐	☐	☐	
63. Chemical Dependency ***(other drug-specify)***	☐	☐	☐	☐	
64. Weight Problems *(obesity or anorexia)*	☐	☐	☐	☐	
65. Infertility	☐	☐	☐	☐	
66. Miscarriages If "Yes" how many	☐	☐	☐	☐	
67. Stillbirths If "Yes" how many	☐	☐	☐	☐	
68. Neonatal Deaths *(died before one month old)*	☐	☐	☐	☐	
69. Infants Death *(died before one year of age)*	☐	☐	☐	☐	
70. Childhood Deaths	☐	☐	☐	☐	
71. HIV *Positive (Human Immunodeficiency Virus)*	☐	☐	☐	☐	
72. AIDS *(Acquired Immunodeficiency Syndrome)*	☐	☐	☐	☐	
73. Frequent Infections *(immunodeficiency)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

SOCIAL/MEDICAL HISTORY OF THE BIRTH FATHER

Father's Age	Year of Birth

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

General Physical Description *(i.e., hair color, eye color, height)*

Highest grade in school he completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College/University

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduated

Was he ever in special education classes? *(classes designed to help in learning)* ☐ Yes ☐ No

List awards, honors, and/or scholarships in high school

Actively participated in school sponsored events, such as

Plans for further education and/or vocational goal, include

Other educational comments

Is he currently employed? ☐ Yes ☐ No

Current Employment *(type of job)*

Previous Employer *(type of job)*

Religious Affiliation

Does he have a preference about the religious affiliation for the child? ☐ Yes ☐ No

If Yes, specify

Was he adopted? ☐ Yes ☐ No ☐ Don't Know

Has he had any major illnesses? ☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Does he have or has he had any mental illness? ☐ Yes ☐ No ☐ Don't Know

If Yes explain and tell about the treatment

Has he ever been told he had a genetic/inherited disease? ☐ Yes ☐ No

If Yes, please explain?

Has he ever been told he was a carrier of a genetic/inherited disease? ☐ Yes ☐ No

If Yes, what disease?

SOCIAL/MEDICAL HISTORY OF THE BIRTH FATHER, cont.

Describe any other children he has *(i.e., the children's brother and sisters)*: List in order of birth and the children who may have died. If a child died, please indicate age at death and the cause of death.

Relationship	Date of Birth	Health/Medical Problems

How many living brothers does he have?

Does he have any brothers who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

How many living sister does he have?

Did he have any sisters who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

Do any of his brothers or sisters have a different father or mother?

If Yes, please indicate which brother or sister and which parent was different

Birth Father's Parents

Mother's year of birth

Has she had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If she is dead: cause of death and age

Highest grade in school she completed *(check one)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did she receive special education? ☐ Yes ☐ No ☐ Don't Know

Father's year of birth

Has he had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If he is dead: cause of death and age

Highest grade in school he completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did he receive special education?

☐ Yes ☐ No ☐ Don't Know

Birth Father's Grandparents

Father's Maternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Maternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Paternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Paternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*
Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER

Genetic Medical History: Indicate by checking "Yes" or "No" if you or any blood relative (i.e. Your parents, grandparents, aunts, uncles, brothers, sisters, nieces, and nephews) ever had or Now have any of the medical conditions listed. Include only relatives who are your blood relatives (omitting relatives only by marriage or adoption, but including half-brothers and half-sisters). Indicate all relatives in terms of their relationship to you.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
1. Blindness or other Visual Problems *(i.e. Cataracts)*	☐	☐	☐	☐	
2. Hearing Impaired Difficulties Unusual shape or ear missing	☐	☐	☐	☐	
3. Speech Problems	☐	☐	☐	☐	
4. Dental Problems *(i.e., missing tooth or extra tooth)*	☐	☐	☐	☐	
5. Cleft Lip *(harelip)*	☐	☐	☐	☐	
6. Cleft Palate	☐	☐	☐	☐	
7. Learning Disability or Slow Learner	☐	☐	☐	☐	
8. Mental Retardation	☐	☐	☐	☐	
9. Attention Deficit Disorder and/or Hyperactivity	☐	☐	☐	☐	
10. Down Syndrome	☐	☐	☐	☐	
11. Other Chromosome Abnormality *(specify)*	☐	☐	☐	☐	
12. Mental Illness *(e.g. manic depression, schizophrenia, nervous breakdown)*	☐	☐	☐	☐	
13. Hydrocephalus *(water on the brain)*	☐	☐	☐	☐	
14. Microcephaly *(small head)*	☐	☐	☐	☐	
15. Patches of Hair of Different Color	☐	☐	☐	☐	
16. Patches of Skin of Different Color	☐	☐	☐	☐	
17. Birthmarks *(i.e., unusual shape, size or number)*	☐	☐	☐	☐	
18. Skin Problems *(i.e., severe eczema, acne)*	☐	☐	☐	☐	
19. Bleeding Problems or Hemophilia	☐	☐	☐	☐	
20. Sickle Cell Disease	☐	☐	☐	☐	
21. Thalassemia *(inherited anemia)*	☐	☐	☐	☐	
22. High Blood Pressure *(hypertension)*	☐	☐	☐	☐	
23. Stroke	☐	☐	☐	☐	
24. Heart Disease before age 50 *(Coronary)*	☐	☐	☐	☐	

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
25. Born with Heart Defect *(i.e., whole in the heart)*	☐	☐	☐	☐	
26. Born with Open Spine *(Spina Befida)*	☐	☐	☐	☐	
27. Born with Missing Brain *(anencephaly)*	☐	☐	☐	☐	
28. Born with Hip Problems *(dislocated hips)*	☐	☐	☐	☐	
29. Dwarfism or Short Statue	☐	☐	☐	☐	
30. Spinal Curvature *(Scoliosis)*	☐	☐	☐	☐	
31. Unusually Formed Bones or Many Broken Bones	☐	☐	☐	☐	
32. Unusually Formed Hands *(i.e., extra, missing, webbed fingers)*	☐	☐	☐	☐	
33. Unusually Formed Feet *(example; extra, missing, webbed toes)*	☐	☐	☐	☐	
34. Club Foot	☐	☐	☐	☐	
35. Other Birth Defects *(Not listed, please specify)*	☐	☐	☐	☐	
36. Arthritis	☐	☐	☐	☐	
37. Muscular Dystrophy	☐	☐	☐	☐	
38. Muscle Weakness	☐	☐	☐	☐	
39. Loss if Muscle Control	☐	☐	☐	☐	
40. Pyloric Stenosis *(projectile vomiting)*	☐	☐	☐	☐	
41. Breast Cancer	☐	☐	☐	☐	
42. Colon Cancer	☐	☐	☐	☐	
43. Ovarian Cancer	☐	☐	☐	☐	
44. Other Cancers *(type, site)*	☐	☐	☐	☐	
45. Cystic Fibrosis	☐	☐	☐	☐	
46. Alzheimer Disease	☐	☐	☐	☐	
47. Huntington Disease	☐	☐	☐	☐	
48. Neurofibromatosis *(benign tumor)*	☐	☐	☐	☐	
49. Multiple Sclerosis	☐	☐	☐	☐	
50. Tay Sachs Disease	☐	☐	☐	☐	
51. Cerebral Palsy	☐	☐	☐	☐	
52. Seizures, Convulsions, Epilepsy	☐	☐	☐	☐	
53. Childhood Diabetes	☐	☐	☐	☐	
54. Adult Diabetes *(insulin active or over active)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
55. Thyroid Disorder *(under active or over active)*	☐	☐	☐	☐	
56. Kidney Problems	☐	☐	☐	☐	
57. Respiratory or Breathing Problems	☐	☐	☐	☐	
58. Asthma	☐	☐	☐	☐	
59. Allergies/Hay Fever *(pollen)*	☐	☐	☐	☐	
60. Allergies Food *(specify)*	☐	☐	☐	☐	
61. Allergies Medicine *(specify)*	☐	☐	☐	☐	
62. Chemical Dependency *(alcohol)*	☐	☐	☐	☐	
63. Chemical Dependency *(other drug-specify)*	☐	☐	☐	☐	
64. Weight Problems *(obesity or anorexia)*	☐	☐	☐	☐	
65. Infertility	☐	☐	☐	☐	
66. Miscarriages If "Yes" how many	☐	☐	☐	☐	
67. Stillbirths If "Yes" how many	☐	☐	☐	☐	
68. Neonatal Deaths *(died before one month old)*	☐	☐	☐	☐	
69. Infants Death *(died before one year of age)*	☐	☐	☐	☐	
70. Childhood Deaths	☐	☐	☐	☐	
71. HIV Positive *(Human Immunodeficiency Virus)*	☐	☐	☐	☐	
72. AIDS *(Acquired Immunodeficiency Syndrome)*	☐	☐	☐	☐	
73. Frequent Infections *(immunodeficiency)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

Prepared By

Assessor	Certificate Number

Ohio Department of Health

Application for Release of Adopted Name

I, _____ being first duly sworn,
(Biological Parent or Sibling's Present Name)

say that I am the biological PARENT or SIBLING
(Circle One)

of: _____
(Adopted Person's Biological Name)

born on _____, in _____
Month Day Year City, County

born to _____.
(Mother's Full Maiden Name)

I hereby request the Ohio Department of Health to provide me with the **adopted name** if the required Authorization of Release of Adopted Name (HEA 3036) form is on file. **Two forms of identification such as motor vehicle or commercial driver's license, identification card, marriage application, social security card, military identification card, or employee identification card must be submitted with the Application for Release of Adopted Name form.** I am aware that other items of identification may be required to verify my relationship to the adopted person. If I am the biological parent, my name **must** be present on the original birth record. If I am a biological sibling, I **must** provide a photocopy of my birth record listing one of the same parents present on the original birth record of the adopted person.

_____ _____
Signature of Biological Parent or Sibling Date

_____
Street Address

_____ _____ _____
City State Zip Code

Sworn to before me and subscribed in my presence, this_____ day of _____ 20 _____.
(Month) (Year)

_____ _____
(Signature of Notary Public) (Date Commission Expires)

Section 3107.49 of the Ohio Revised Code states "A birth parent, or birth sibling age twenty-one or older, may submit a request to the department of health for assistance in finding an adopted person's name by adoption. The department shall examine the adopted person's adoption file to determine the adopted person's name by adoption and provide the birth parent or birth sibling with the adopted person's name by adoption if all of the criteria under this section of code are met."

— This form must be notarized prior to submission —

The completed authorization form should be mailed to:
Ohio Department of Health
Attn: Special Registration
P.O. Box 15098
Columbus, Ohio 43215

Ohio Department of Health