



**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 your birth parents or other family members;
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. 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 information for the first time.  I am updating information previously submitted.

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

- Adoptee at least 18  Adoptive parent of an adoptee under 18

**I. ADOPTEE'S INFORMATION**

ADOPTEE'S CURRENT NAME (Last, First, Middle)		ADOPTEE'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 known)	
LOCATION WHERE ADOPTION WAS FINALIZED (City/County, State)		DATE ADOPTION WAS FINALIZED (MM/DD/YYYY)			
CURRENT STREET ADDRESS		CITY	STATE	ZIP CODE	

**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:

- My birth parent, provided I am at least 21.  
 Parent of my birth parent if I am at least 21, if my birth parent is incapacitated or deceased.

My birth sibling if we are both 21 and:

- My sibling remained with the birth parent and has consent of the birth parent, unless incapacitated or deceased.  
 My sibling and I were both adopted out of the same birth family.  
 My sibling was not adopted out of the same birth family but did not remain with the birth parent.

- My descendants.

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

- I wish to have contact with my birth child.  I do not wish to have contact with my 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 ADOPTEE (IF AT LEAST 18) OR ADOPTIVE PARENT (FOR ADOPTEE UNDER 18)	DATE



**REGISTRATION INFORMATION**

**II. BIRTH MOTHER'S INFORMATION IF KNOWN (IDENTIFYING)**

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)**

**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**

Light   
  Olive   
  Medium   
  Dark     
  Right-handed   
  Left-handed

**III. BIRTH FATHER'S INFORMATION IF KNOWN (IDENTIFYING)**

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)**

**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**

Light   
  Olive   
  Medium   
  Dark     
  Right-handed   
  Left-handed

**IV. ADOPTIVE PARENT'S INFORMATION (IDENTIFYING)**

ADOPTIVE PARENT'S NAME (Last, First Middle)		MAIDEN NAME (if applicable)	
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE

**ADOPTIVE PARENT'S INFORMATION (IDENTIFYING)**

ADOPTIVE PARENT'S NAME (Last, First Middle)		MAIDEN NAME (if applicable)	
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE



**V. ADOPTEE'S BACKGROUND INFORMATION (NON-IDENTIFYING)**

<b>HIGHEST GRADE LEVEL ACHIEVED</b>	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
<b>I WOULD DESCRIBE MYSELF AS:</b>	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
<b>MARITAL STATUS</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>CHILDREN</b>	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	
<b>RACE/ETHNICITY (Check all that apply)</b>				
<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				
<b>HEIGHT</b>	<b>WEIGHT</b>	<b>EYE COLOR</b>	<b>HAIR COLOR</b>	<b>HAIR TYPE</b>
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight
<b>COMPLEXION</b>			<b>HANDEDNESS</b>	
<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	

**VI. ADOPTEE'S PREGNANCY INFORMATION (NON-IDENTIFYING)**

<b>AGE AT FIRST MENSTRUAL PERIOD</b>	<b>IF APPLICABLE, AGE AT MENOPAUSE</b>	<b>NUMBER OF PREGNANCIES</b>
<b>NUMBER OF LIVE BIRTHS</b>	<b>NUMBER OF MISCARRIAGES</b>	<b>MULTIPLE BIRTHS</b>
		<input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other: _____
<b>HISTORY OF REPRODUCTIVE SYSTEM PROBLEMS</b> <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"/> Ovarian Cysts (Benign) <input type="checkbox"/> Endometriosis <input type="checkbox"/> Other _____		
<b>COMPLICATIONS DURING THIS PREGNANCY</b> <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 _____		
<b>ANY INJURY DURING PREGNANCY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below)		
<b>X-RAY PROCEDURES DURING PREGNANCY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Month of Pregnancy: _____)		
If YES, purpose of X-Ray:		
<b>DISEASES DURING PREGNANCY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list below)		
<b>DISEASE</b>	<b>TREATMENT</b>	
<b>LENGTH OF PREGNANCY?</b>	<input type="checkbox"/> Premature - Number of weeks early: _____ <input type="checkbox"/> Full-Term <input type="checkbox"/> Post-Term - Number of weeks late: _____	
<b>TOBACCO USE DURING PREGNANCY?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of cigarettes daily: _____)	
<b>ALCOHOL USE DURING PREGNANCY?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of drinks weekly: _____)	
<b>LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY</b>		
<b>DURATION OF LABOR</b>	Hours: _____	<b>TYPE OF DELIVERY</b>
		<input type="checkbox"/> Spontaneous <input type="checkbox"/> Breech <input type="checkbox"/> Breech <input type="checkbox"/> Caesarean
<b>COMPLICATIONS DURING DELIVERY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below)		



**VII. ADOPTEE'S MEDICAL HISTORY (NON-IDENTIFYING)**

This section is for the adoptee or the adoptee's adoptive family or legal guardian to complete medical information about the adoptee. Check all that apply.

**ALLERGIES**

ENVIRONMENTAL		FOOD		OTHER (specify):
PLANT				
ANIMAL		DRUG/CHEMICAL		

**EAR & EYE CONDITIONS**

CATARACTS		FAR-SIGHTED		OTHER (specify):
GLAUCOMA				
COLOR BLINDNESS		ASTIGMATISM		
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

**BLOOD, HEART & CIRCULATORY CONDITIONS**

HEART ATTACK		HIGH BLOOD PRESSURE		OTHER (specify):
STROKE		ANEMIA		
HARDENING OF THE ARTERIES		HEMOPHILIA		
BLOOD CLOTS IN THE LEGS		SICKLE CELL ANEMIA		

**BRAIN & NERVOUS SYSTEM CONDITIONS**

ALZHEIMER'S DISEASE		PARKINSON'S DISEASE		OTHER (specify):
MULTIPLE SCLEROSIS		MIGRAINE HEADACHES		
EPILEPSY & OTHER SEIZURE OR CONVULSIVE CONDITIONS		HUNTINGTON'S DISEASE		
CEREBRAL PALSY		TOURETTE'S SYNDROME		

**HORMONAL DISORDERS**

DIABETES		OTHER (specify):		
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		



**INTELLECTUAL & DEVELOPMENTAL CONDITIONS**

DOWN SYNDROME		OTHER (specify):		
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

**MENTAL & BEHAVIORAL CONDITIONS**

SCHIZOPHRENIA		ATTENTION DEFICIT DISORDER (ADD)		OTHER (specify):
ANXIETY DISORDER		ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)		
MAJOR DEPRESSIVE DISORDER		DRUG ABUSE		
BIPOLAR DISORDER (MANIC DEPRESSIVE)		POST-TRAUMATIC STRESS DISORDER		
ALCOHOLISM		ANOREXIA NERVOSA		
OBSSIVE COMPULSIVE DISORDER				

**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		Cause:	<input type="checkbox"/> Gall stones	<input type="checkbox"/> Infection <input type="checkbox"/> Tumor
ULCERS		OTHER (specify):		
DIVERTICULITIS				
ULCERATIVE COLITIS/ CROHN'S DISEASE				

**CANCER**

BLOOD (Leukemia)		BRAIN		OTHER (specify):
COLON		HODGKIN'S DISEASE		
PROSTATE		PANCREAS		
UTERINE		LIVER		
BREAST		OVARIAN		
LUNG		CERVICAL		
SKIN		STOMACH		
BONE		THROAT		



GENETIC CONDITIONS			
MUSCULAR DYSTROPHY	<input type="checkbox"/>	MARFAN'S SYNDROME	<input type="checkbox"/>
SPINA BIFIDA	<input type="checkbox"/>	TAY-SACHS DISEASE	<input type="checkbox"/>
CLUB FOOT	<input type="checkbox"/>	HARE LIP	<input type="checkbox"/>
DWARFISM	<input type="checkbox"/>	CLEFT PALATE	<input type="checkbox"/>
CYSTIC FIBROSIS	<input type="checkbox"/>	OTHER (specify):	
OTHER CONDITIONS			
HIGH CHOLESTEROL	<input type="checkbox"/>	OBESITY	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	Specify:	
EXPOSURE TO CHEMICALS & TOXIC MATERIALS	<input type="checkbox"/>		

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.

<b>SIGNATURE</b>		<b>DATE</b>	
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