THE WORLD OF PEDIATRICS

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ADOPTION CLIENT INFORMATION FORM

Date: _____

Information of Individual(s) requesting evaluation:

Name: _____ Email: _____

Cell Phone: (____)_____ Work Phone: (____)_____ Work Fax: (____)_____

Individual's relationship to the child: ❑ Worker/ Organization Assisting ❑Prospective Parent ❑Other

Where To Contact?: ❑ Home ❑Work How to Contact?: ❑ Email ❑Cell Phone ❑Fax ❑ Telephone Time?: _____

Name: _____ Email: _____

Cell Phone: (____)_____ Work Phone: (____)_____ Work Fax: (____)_____

Individual's relationship to the child: ❑ Worker/ Organization Assisting ❑Prospective Parent ❑Other

Where To Contact?: ❑ Home ❑Work How to Contact?: ❑ Email ❑Cell Phone ❑Fax ❑ Telephone Time?: _____

Home Address (if applicable):_____

City: _____ State:_____ Zip:_____

Home Phone: (____)_____ Home Fax: (____)_____ Home Email:_____

Child's Information

Name: *First* _____ *Middle*_____ *Last* _____

Preferred Name: _____ Date of Birth:_____ Age: _____ Sex: ❑M ❑F

Child's Birth City and Country: _____

How has child been cared for? ❑ Foster Care ❑Orphanage ❑Other:_____

Name and Place of Orphanage (if applicable): _____

Date Placed in Orphanage or Foster Care: _____

What Materials Do You Want Evaulated? ❑ Medical Records ❑Pictures ❑Video Tape ❑Other:_____

Date Pictures Were Taken: _____ *Age:* _____ Date Video Tape Was Taken: _____ *Age*: _____

If more than one child is present in the pictures or video tape, please, specify which child should be evaluated:

_____

_____

_____