

INFORMATION ABOUT THE BIRTH FATHER

CHILD'S NAME		CASE NUMBER
CASE WORKER'S NAME	AGENCY'S NAME	

INSTRUCTIONS FOR COMPLETION:

- Print clearly - using ink.
- Complete all items. If you don't know the answer to an item, indicate "unknown".
- The AD 67A form is divided into two separate parts. Section I consists of "identifying" information and will be kept confidential. None of this information will be released to your adopted child or his/her adoptive parent(s) unless you give us written permission to release it. Section II consists of "nonidentifying" information. California Adoption Law requires that a copy of Section II which is medical, psychological and social information be released to your child's adoptive parent(s) before finalization of the adoption and upon written request from your adopted child when he/she reaches age 18.
- All information requested on this form is required for the completion of your child's adoption.

SECTION I — IDENTIFYING INFORMATION ABOUT BIRTH FATHER

This information will be kept confidential unless you give written permission to release it.

A. NAME/ADDRESS

BIRTH FATHER'S NAME (FIRST, MIDDLE, LAST)				OTHER NAMES KNOWN BY
SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	DATE OF BIRTH (MO, DAY, YR)	BIRTHPLACE (CITY, STATE, COUNTRY)	
CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)				TELEPHONE NUMBER ()
PERMANENT MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE) *				PERMANENT TELEPHONE NUMBER ()
RESTRICTIONS FOR USE OF PERMANENT MAILING ADDRESS, IF ANY				

B. BIRTH FATHER'S PARENTS (The parents who raised you)

NAME OF BIRTH FATHER'S MOTHER (FIRST, MIDDLE, LAST)			NAME OF BIRTH FATHER'S FATHER (FIRST, MIDDLE, LAST)		
ADDRESS	STREET	CITY	ADDRESS	STREET	CITY
STATE		ZIP CODE	STATE		ZIP CODE
DOES YOUR MOTHER KNOW ABOUT THIS ADOPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			DOES YOUR FATHER KNOW ABOUT THIS ADOPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR MOTHER FOR ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR FATHER FOR ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

C. PATERNITY OF MINOR

Have you and the child's birth mother ever been married?..... Yes No

If yes, date and place of marriage: _____

If divorced, date and place of divorce: _____

Have you and the child's birth mother ever attempted to marry?..... Yes No

If yes, explain: _____

Are you currently married to the birth mother? Yes No

* NOTE: It is important that you notify the California Department of Social Services of any changes in your permanent mailing address.

D. OTHER CHILDREN

Do you have other children in addition to the child being adopted? Yes No

If yes, complete the following:

NAME OF CHILD	GENDER		CHECK (✓) IF BLOOD RELATED TO ADOPTEE		CHILD'S DATE OF BIRTH	WHO IS TAKING CARE OF THIS CHILD? <i>(Specify caretaker's relation to child)</i>
	M	F	FULL	HALF		
1.						
2.						
3.						
4.						

E. AMERICAN INDIAN ANCESTRY (ICWA-020 form must be completed)

Does anyone in your family on your mother or father's side have any American Indian Ancestry? Yes No

If yes, what tribe(s)? _____ What is the location of the tribe(s)? _____

Are you or your parents presently registered with the tribe or have any other ancestors ever been registered with the tribe? Yes No

If yes, what is your or their enrollment number(s)? _____

Have you, your parents, grandparents or any other ancestor ever had a Certificate of Degree of Indian Blood (CDIB)? Yes No

If yes, please attach a copy of the CDIB to this questionnaire.

F. PSYCHOLOGICAL COUNSELING

Have you ever gone to a psychologist, psychiatrist, clinical social worker, mental health or behavioral health therapist for any emotional or psychological or behavioral problems you may have had? Yes No

If yes, complete the following:

DATE(S) AND REASONS FOR TREATMENT

NAME OF THERAPIST AND/OR AGENCY THAT PROVIDED TREATMENT

LOCATION

INDICATE MEDICATIONS PRESCRIBED DURING YOUR TREATMENT

REASON FOR DISCONTINUANCE IF NO LONGER UNDER TREATMENT

G. ADOPTION QUESTIONS (For Independent Adoptions Only)

- 1. Is an attorney representing you during this adoption? Yes No
- 2. Is your attorney also representing the adopting parent(s)? Yes No Unknown
- 3. Who paid the expenses for this pregnancy, including prenatal care, delivery and any other expenses? _____
- 4. How much did they pay? (Please indicate if unknown) _____
- 5. Did the adopting parent(s) pay any of the birth mother's living expenses? Yes No Unknown
- 6. California adoption law states that birthparents who place a child for adoption must have personal knowledge about the adopting parent(s).

Please indicate whether you have the following information about the adopting parent(s):

- | | | | |
|--|--|------------------------------|--|
| Full Legal Name | <input type="checkbox"/> Yes <input type="checkbox"/> No | Age | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Religion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Race or ethnicity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Length of current marriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Number of previous marriages | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| General area of residence (if requested, their address) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Employment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Whether other children or adults live in their home | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Children who do not live in the home | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Any child support obligation for these children | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Any failure to meet child support obligation | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Health conditions restricting normal daily activities or reducing normal life expectancy | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Any History of arrest and convictions for any crimes other than minor traffic violations | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Any removals of children from care due to child abuse or neglect | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

7. What additional information do you want or need about the adopting parent(s)? _____

8. Have you met the adopting parent(s)? Yes No

9. If yes, how well acquainted are you with them? _____

SIGNATURE OF BIRTH FATHER

DATE FORM COMPLETED

The above information was provided by: (Check applicable box)

- Birth Mother Birth Father Other (explain) _____

CHILD'S NAME	CASE NUMBER
CASE WORKER'S NAME	AGENCY'S NAME

SECTION II — NON IDENTIFYING INFORMATION ABOUT BIRTH FATHER

This information will be released to the adopting parent(s) and will be available to your child. Please answer all questions as completely as possible.

CHARACTERISTICS OF BIRTH FATHER AT TIME OF ADOPTEE'S BIRTH

A. GENERAL INFORMATION AND PHYSICAL DESCRIPTION

HEIGHT	USUAL WEIGHT	EYE COLOR	SKIN COLOR	NATURAL HAIR COLOR	NATURAL HAIR TEXTURE (CHECK ALL THAT APPLY) <input type="checkbox"/> FINE <input type="checkbox"/> MEDIUM <input type="checkbox"/> COARSE <input type="checkbox"/> STRAIGHT <input type="checkbox"/> WAVY <input type="checkbox"/> CURLY <input type="checkbox"/> BALDING
BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH FACTOR	BODY TYPE <input type="checkbox"/> SMALL BONED <input type="checkbox"/> MEDIUM BONED <input type="checkbox"/> LARGE BONED	ARE YOU RIGHT HANDED? <input type="checkbox"/> LEFT HANDED? <input type="checkbox"/>

RACE/ETHNIC GROUP

White Hispanic Filipino Black Asian or Pacific Islander
 American Indian or Alaskan Native Other (Specify) _____

If American Indian or Alaskan Native, please specify name of tribe and degree of Indian blood (if known) _____

SPECIFIC NATIONALITY DESCENT (EXAMPLE: IRISH, FRENCH, GERMAN, CANTONESE, MEXICAN, NIGERIAN)

B. EDUCATION:

LAST GRADE COMPLETED	PRESENTLY IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	USUAL GRADES IN SCHOOL	OTHER TRAINING
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EXTRA CURRICULAR ACTIVITIES

SUBJECTS INTERESTED IN

C. OCCUPATION

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION?
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WHAT ARE YOUR OCCUPATIONAL GOALS? (EXAMPLE; TO BE A TEACHER, WELDER, SALES CLERK)

D. PERSONALITY

DESCRIBE YOUR PERSONALITY IN TERMS OF YOUR USUAL BEHAVIOR, ATTITUDES, MOODS, ACTIVITIES YOU USUALLY PARTICIPATE IN, TYPES OF PEOPLE YOU ENJOY BEING WITH, ETC.

DESCRIBE TALENTS, HOBBIES AND GOALS IN LIFE

DESCRIBE HOW YOU WERE AS A CHILD

F. PERSONAL HEALTH HISTORY

DESCRIBE YOUR GENERAL HEALTH

WHAT CHILDHOOD DISEASES HAVE YOU HAD?

- MEASLES: RUBELLA (3 DAY) MUMPS HAYFEVER EAR INFECTIONS RHEUMATIC FEVER WHOOPING COUGH
 RUBEOLA (2 WEEK) CHICKEN POX ROSEOLA ENCEPHALITIS HEART MURMUR URINARY/BLADDER INFECTIONS
 ASTHMA MENINGITIS SCARLET FEVER OTHER (*Specify*) _____

ANY MAJOR SURGERY? YES NO
 IF YES, FOR WHAT CONDITIONS/AND WHEN? _____

ARE YOU A:

- TWIN TRIPLET OTHER MULTIPLE BIRTH

ARE YOU AN:

- IDENTICAL OR FRATERNAL TWIN

DID YOU USE ALCOHOL, TOBACCO OR OTHER DRUG SUBSTANCES PRIOR TO THE CHILD'S CONCEPTION? YES NO
 IF YES, LIST THE TYPE OF SUBSTANCE, HOW LONG IT WAS USED AND HOW FREQUENTLY.

G. FAMILY HISTORY

WERE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY ADOPTED? YES NO
 IF YES, PLEASE INDICATE WHO:

	YOUR BIOLOGICAL FATHER		YOUR BIOLOGICAL MOTHER	
Current age				
If deceased, age at death				
Cause of death				
Height & Weight	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture				
Eye color				
Skin color				
Left or right handed				
Outstanding features				
Education completed				
Occupation				
Race/Ethnic Group	<input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> BLACK <input type="checkbox"/> FILIPINO <input type="checkbox"/> OTHER (<i>SPECIFY</i>) <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE		<input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> BLACK <input type="checkbox"/> FILIPINO <input type="checkbox"/> OTHER (<i>SPECIFY</i>) <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE	
Nationality				
Religion				
Was this parent aware of the pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
How many brothers or sisters did she/he have?				
If any of your aunts or uncles have died, give age at death and cause of death				
	YOUR FATHER'S PARENTS		YOUR MOTHER'S PARENTS	
	FATHER	MOTHER	FATHER	MOTHER
Age				
If deceased, age at death and cause of death				
Describe physical appearance				
Height & Weight	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Outstanding features				
Education completed				
Current or former occupation				
Was he/she aware of the pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

G. FAMILY HISTORY (Continued)

YOUR BROTHERS AND SISTERS

(If you have more than 4 siblings, please use additional paper)

	1		2		3		4	
Gender (Male or Female)								
Age								
If deceased, age at death and cause								
Full or half sibling to you?	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF
Height & Weight	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture								
Eye color								
Skin color								
Hobbies and talents								
Last grade completed								
Presently in school?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Occupation								
Aware of pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Marital status								
Number of children they have								
Health of their children								

YOUR OTHER CHILDREN

(If you have more than 4 children, please use additional paper)

	CHILD #1		CHILD #2		CHILD #3		CHILD #4	
Indicate if son or daughter								
Birthdate or age								
Is this child a full or half sibling to the adoptee?	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF	<input type="checkbox"/> FULL <input type="checkbox"/> HALF
If deceased, age at death								
Cause of death								
Height & Weight	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture								
Eye color								
Skin color								
Left or right handed								
Grade in school								
Does this child live with you?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hobbies and talents								
General health								
Major surgery								
Health problems								
Was this child aware of the pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

H. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Please complete "Comments" section. If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in "Comments" section.

MEDICAL CONDITION	NO	Not Known	YES Self	YES - RELATIVE <i>(Specify relationship)</i>	COMMENTS
A. CONGENITAL IMPAIRMENTS					
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.)					
2. Harelip (cleft lip) or cleft palate					
3. Down's Syndrome					
4. Other chromosome abnormality					
5. Hydrocephalus					
6. Muscular dystrophy					Parts of body involved? Age at onset?
7. Dwarfism					
8. Spina bifida					
9. Congenital heart defect					
10. Sickle Cell Anemia					
11. Tay-Sachs disease					
B. ALLERGIES					To what allergies? What treatment? What medication?
1. Eczema or other skin condition					
2. Hay fever or other allergy					
3. Drug allergy					To what drugs?
4. Food allergy					To what foods?
C. EYE, DENTAL, EAR, AND DEVELOPMENTAL DISORDERS					
1. Blindness, glaucoma, color blindness or other visual problems					
2. Corrective glasses or contact lenses					At what age were prescription lenses necessary?
Nearsighted					
Farsighted					
Astigmatism (inability to focus)					
Strabismus (crosseye)					
Other (explain)					
3. Braces on teeth or other orthodontia work					If so, what orthodontic work and for how long?

H. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES - RELATIVE <i>(Specify relationship)</i>	COMMENTS
4. Deafness or other ear problems					Special education? If "Yes", indicate age at onset.
5. Speech problems					
6. Learning disability					Any diagnosis? Hospitalization?
7. Developmental disability					
D. CIRCULATORY DISORDERS					
1. Hemophilia					
2. Sickle cell anemia or trait					
3. Hypertension (high blood pressure)					Age at onset? What treatment? Hospitalization?
4. Stroke					
5. Heart attack (coronary)					
6. Arthritis					What kind? Age at onset? What part of body?
7. Kidney disease					Age at onset? What treatment?
E. HORMONAL DISORDERS					Age at onset? What treatment?
1. Diabetes					
2. Thyroid disorder					
3. Obesity (overweight)					
F. RESPIRATORY DISORDERS					Any cause known? What treatment?
1. Asthma					
2. Emphysema					Age at onset?
3. Tuberculosis					Age at onset? What kind? What part of body?
G. MENTAL AND BEHAVIORAL DISORDERS					Age at onset? What treatment? Hospitalization?
1. Diagnosed schizophrenia					
2. Diagnosed bi-polar					
3. Other mental illness. Describe, using additional page, if necessary					
4. Alcoholism or heavy drinking					
5. Drug usage					Kind, amount, and when taken?

H. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES - RELATIVE (Specify relationship)	COMMENTS
H. LYMPHATIC DISORDERS					What kind? Age at onset? What part of body?
1. Cancer					
2. Tumors					
3. Cystic fibrosis					
4. Hodgkins disease					
I. NERVOUS SYSTEM DISORDERS					Parts of body involved? Age at onset?
1. Multiple sclerosis					
2. Huntington's disease					
3. Cerebral palsy					
4. Seizures or convulsions					Age at onset? What treatment? Frequency?
5. Epilepsy					
J. INFECTION, HOSPITALIZATION					Diagnosis?
1. Repeated attacks of fever with known infection					
2. Repeated severe infection necessitating hospitalization					
3. Hospitalization, operation, or injury					What for? When?
K. OTHER MEDICAL OR HEALTH PROBLEMS					