



Guidance for Completing State Form 9966

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Statutory Authority: I.C. 31-19-2-7

Time of Filing: The original copy of this form shall be filed with the Clerk of Court accompanying the petition, or within sixty (60) days of the filing of the petition for adoption.

Fee: The Clerk of Court shall collect an Adoption Medical History Fee of twenty dollars (\$20) in each proceeding for adoption.

Disposition: The original copy of this form, including additional pages (if applicable), is to be sent to the State Registrar attached to the Record of Adoption (SF5438). A photocopy of the Medical History Report (Section II) should be given to the adoptive parents anytime during the proceeding.

Subsequent requests for copies of this report, or any other information contained in the Indiana Adoption Medical History Registry, **MUST BE** directed to the State Registrar of Vital Records. (I.C. 31-19-18-1)

General Guidance: All items, except the written signature in Section I, must be typed or clearly printed. Because this form will be photocopied and microfilmed, information must be completed in black ink.

Section I - Affirmation: When completed, Section I will contain confidential information and is for the use of the court and State Registrar only. Section I will not be photocopied when making a copy of the Medical History.

Section II - Medical History: When completing the Medical History, please keep in mind that the recipient of this information will probably not be a physician or an attorney. The Medical History should be completed in language that the average person would convey information to a family physician.

- The Medical History check boxes are provided for the conditions listed in Items 1 through 6 i. Medical History information may be provided for the birth mother, birth father, birth family, and adopted person.

For the purpose of this report, the birth (biological) family of the adopted person should be limited to grandparents and siblings. Other family members may be included if the medical information is significantly pertinent to the Medical History.

- Medical History information for conditions listed in Items 1 through 6 i. is reported by placing an "X" in the appropriate box for the person(s) having the condition. If medically pertinent, brief supplementary information can be entered in the Details section.

- Shaded check boxes indicate that the condition is not applicable or medically insignificant for that person(s).

- 6 j. **Newborn Screening Disorders - I.C. 16-41-17-2*** requires that "...every infant shall be given examinations at the earliest feasible time for the detection of the following disorders: (1) Phenylketonuria; (2) Hypothyroidism; (3) Hemoglobinopathies, including sickle cell anemia; (4) Galactosemia; (5) Maple Syrup urine disease; (6) Homocystinuria; (7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department; (8) Congenital adrenal hyperplasia; (9) Biotinidase deficiency; and (10) Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry..."

***I.C. 16-41-17-2 became effective on July 1, 1985. Therefore, 6 j. applies to individuals born on or after July 1, 1985. Positive results and/or follow-up tests should be noted in the Details section.**

- 6 k. **Birth Weight, Length, and APGAR Scores** - This information should be entered in the Details section if the adopted person is less than three (3) years of age and the information is known.
7. **Deaths of BIRTH family members that may affect the Medical History** - Information must be limited to deaths due to causes that are significantly pertinent to the Medical History and stated in the Details section.

Details Section: Supplementary information for medical conditions reported in Section II, Items 1-7, should be reported in this section. The condition should be identified by item number and suffix letter, if applicable, e.g., 6 a., and *briefly* report additional information that *must include* the person having the history (title only) and may include the age at onset if medically significant. If additional pages are needed to complete the Details section, plain white paper (8 1/2" X 11"), with the headings, "Item/Details," should be used, with printing on only one side of the paper. Each page, including the original form, should include the page number and the total number of pages in the Medical History Report. **Care must be taken when detailing the medical condition(s), because the contents of this report must not contain any information that could lead to the identification of any person.**

