The Arizona Department of Child Safety is required to provide prospective adoptive parents with all non-identifying information about the child to be adopted. This form and any attachment contain all non-identifying information known to DCS as of the date of placement in the adoptive home.

WHEN DELETING INFORMATION FROM THIS FORM, DRAW A LINE THROUGH IT. DO NOT BLACK OUT ANY INFORMATION. ADD SUPPLEMENTAL PAGES IF NECESSARY.

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| **CHILD’S HISTORY** | | | | | | | | | | |
| CHILD’S FIRST NAME | | | DATE OF BIRTH | | BIRTHPLACE *(State or Country)* | | | | ETHNICITY | |
| TRIBAL AFFILIATION | | | ELIGIBLE FOR ENROLLMENT  Yes No | | | | BLOOD TYPE | | | |
| TIME OF BIRTH         a.m.  p.m. | | | FULL-TERM GESTATION  Yes No | LENGTH AT BIRTH | | | | APGAR SCORE | | DAYS IN HOSPITAL |
| WAS RESUSCITATION REQUIRED?  Yes No | COMPLICATION OF BIRTH *(Include any birth injury to child)* | | | | | CIRCUMCISED | | |  |  |
| Yes *(Date:*      *)* No N/A | | | | |
| DID MOTHER RECEIVE PRE-NATAL CARE? | DID MOTHER HAVE ANY SURGERY OR ILLNESSES DURING THIS PREGNANCY? If Yes, give details  Yes No | | | | | | | | | |
| Yes No |
| WAS CHILD SUBSTANCE EXPOSED AT BIRTH?  Yes No | | FOR WHAT SUBSTANCES DID THE CHILD OR MOTHER TEST POSITIVE? | | | | | | | | |

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| **OBTAIN AND ATTACH BIRTH RECORDS FROM THE HOSPITAL.** |

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| **REASON CHILD IS IN CARE** |
| *REASON FOR PLACEMENT IN OUT-OF-HOME CARE (Provide a detailed account of the circumstances that caused the out-of-home care placement(s) and the reason(s) the child was unable to return to the family of origin. Include any incidents of physical, sexual or emotional abuse or neglect of which the child was a victim.)* |
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| **INCIDENTS OF ABUSE, NEGLECT AND TRAUMA TO THE CHILD WHILE IN THE CARE OF THE DEPARTMENT** |
| ABUSE, NEGLECT AND TRAUMA TO THE CHILD *(Provide a detailed account of acts and the outcome of acts of physical or sexual abuse or neglect suffered by the child while in the care of the Department. Include and describe incidents of accidental trauma the child may have suffered and the outcome.)* |
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| **ABUSE PERPETRATED BY THE CHILD** |
| HISTORY OF ABUSE PERPETRATED BY THE CHILD (*Provide a detailed account of acts of physical or sexual abuse perpetrated by the child. Include all information relating to the circumstances such as injury to victim and outcome.)* |
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| **MEDICAL/DEVELOPMENTAL/MENTAL HEALTH HISTORY** | | | | | | | | | |
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| HISTORY OF IMMUNIZATIONS AND TESTS *(Check  applicable boxes and enter appropriate dates)* | | | | | | | | | |
| TYPE | DATE | TYPE | DATE | TYPE | DATE | TYPE | DATE | TYPE | DATE |
| DTaP |  | Varicella |  | Hep A |  | Hep B |  | RV |  |
| MMR |  | Hib |  | IPV |  | PVC |  | Tetanus  Booster |  |

ALLERGIES/ILLNESSES AND DISEASES (list any illness, disease or medical condition for which child has been treated)

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DEVELOPMENTAL CONDITIONS AND TREATMENT (list any developmental delays or disabilities for which the child has received services)

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BEHAVIORAL/MENTAL HEALTH DIAGNOSES AND TREATMENT (list any behavioral or mental health condition for which child has been treated)

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| **PLACEMENT HISTORY** | | |
| Date  Month/Year | Type of Placement  *(Such as Adoptive Home, Foster Home)* | Reason for  Removal |
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| SCHOOL HISTORY | | | |
| Names and Addresses of Schools | Dates Attended | Grade or Class | Problems Encountered |
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ACADEMIC PERFORMANCE*(Include any educational special needs such as placement in special education classes, resource rooms, speech therapy, etc. Attach*

*IEPs and other documents)*

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EDUCATIONAL EVALUATIONS FROM SCHOOLS *(Provide dates, names of evaluators and results. List all attachments with name of documents and dates)*

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| **NON-IDENTIFYING INFORMATION – MOTHER** | | | | | | | | | |
| MOTHER’S DATE OF BIRTH | | | BIRTHPLACE *(State or Country)* | | | | |  | |
| MOTHER’S PHYSICAL DESCRIPTION | | | | | | | | | |
| HEIGHT | WEIGHT | COLOR OF EYES | | HAIR COLOR | | BUILD | AGE AT ONSET OF MENSTRUATION | | RIGHT-HANDED LEFT-HANDED |
| RELATIONSHIP BETWEEN BIRTH PARENTS Married Divorced Separated Living Together Widowed Other *(Explain)* | | | | | | | | | |
| NUMBER AND DURATION OF MARRIAGES | | | | | WAS ANYONE IN MOTHER'S FAMILY ADOPTED *(e.g., parent, sibling)?* | | | | |
| ETHNIC/RACIAL BACKGROUND | | | | | PRIMARY LANGUAGE | | | | |
| TRIBAL AFFILIATION | | | | | ELIGIBLE FOR ENROLLMENT | | | | |
| Yes No | | | | |
| RELIGIOUS AFFILIATION | | | | | | | | | |
| NUMBER OF YEARS ATTENDED SCHOOL | | | | | | DEGREES RECEIVED | | | |

ALLERGIES/ILLNESSES AND DISEASES (list any illness, disease or medical condition for which mother was treated)

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FAMILY ILLNESSES AND DISEASES (list any illness, disease or medical condition that runs in the mother's family (grandparents, child's siblings, aunts, uncles)

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MENTAL HEALTH/PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSES AND TREATMENT (list any mental disorders for which mother was treated)

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FAMILY MENTAL HEALTH/PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSES AND TREATMENT (list any mental disorders for which someone in mother's

family was treated)

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| DOES MOTHER HAVE A HISTORY OF ALCOHOL ABUSE?  Yes  No | | DOES MOTHER HAVE A HISTORY OF DRUG ABUSE?  Yes  No | |

LIST MEDICATIONS, DRUGS AND ALCOHOL USED

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| **NON-IDENTIFYING INFORMATION – FATHER** | | | | | | | |
| FATHER’S DATE OF BIRTH | | | BIRTHPLACE *(State or Country)* | | |  | |
| FATHER’S PHYSICAL DESCRIPTION | | | | | | | |
| HEIGH | WEIGHT | COLOR OF EYES | | HAIR COLOR | BUILD | | RIGHT-HANDED LEFT-HANDED |
| RELATIONSHIP BETWEEN BIRTH PARENTS Married Divorced Separated Living Together Widowed Other *(Explain)* | | | | | | | |
| NUMBER AND DURATION OF MARRIAGES | | | | | WAS ANYONE IN FATHER’S FAMILY ADOPTED *(e.g., parent, sibling)?* | | |
| ETHNIC/RACIAL BACKGROUND | | | | | PRIMARY LANGUAGE | | |
| TRIBAL AFFILIATION | | | | | ELIGIBLE FOR ENROLLMENT | | |
| Yes No | | |
| RELIGIOUS AFFILIATION | | | | | | | |
| NUMBER OF YEARS ATTENDED SCHOOL | | | | | DEGREES RECEIVED | | |

ALLERGIES/ILLNESSES AND DISEASES (list any illness, disease or medical condition for which father was treated)

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FAMILY ILLNESSES AND DISEASES (list any illness, disease or medical condition that runs in the father's family (grandparents, child's siblings, aunts, uncles)

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MENTAL HEALTH/PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSES AND TREATMENT (list any mental disorders for which father was treated)

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FAMILY MENTAL HEALTH/PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSES AND TREATMENT (list any mental disorders for which someone in father's

family was treated)

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| DOES FATHER HAVE A HISTORY OF ALCOHOL ABUSE?  Yes  No | | DOES FATHER HAVE A HISTORY OF DRUG ABUSE?  Yes  No | |

LIST MEDICATIONS, DRUGS AND ALCOHOL USED

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| **CHILD’S SIBLINGS** | | | | | |
| Current Placement: AH–Adoptive Home; FH–Foster Home; PH–Parent’s Home; RH–Relative’s Home; O–Other; UNK-Unknown | | | | | |
|  | **SIBLING 1** | **SIBLING 2** | **SIBLING 3** | **SIBLING 4** | **SIBLING 5** |
| CURRENT PLACEMENT |  |  |  |  |  |
| GENDER |  |  |  |  |  |
| DATE OF BIRTH |  |  |  |  |  |

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| ILLNESSES AND DISEASES (list any illness, disease or medical condition for which any siblings have been treated) | | | |
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| MENTAL HEALTH/PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSES AND TREATMENT (list any mental disorders for which any siblings have been treated) | | | |
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| Are any siblings deceased?  Yes  No | | If yes, cause of death: | |
|  | | | |
| Provide significant information about the relationship between siblings | | | |

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| **ACKNOWLEDGEMENT** | | |
| INFORMATION AND RECORDS PROVIDED | | |
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# The adoptive parent(s) acknowledge that the Department of Child Safety (DCS) has provided information about the child's

# history including the reason the child is in care; abuse, neglect and trauma while in care; the child's medical and mental health conditions

# and treatment; placements and education.

The adoptive parent(s) acknowledge that DCS has provided the opportunity to consult with medical, behavioral health or school

professionals who are familiar with the child's needs.

The adoptive parent(s) acknowledge that there may be information that DCS does not have, cannot obtain and therefore cannot disclose.

The adoptive parent(s) acknowledge that DCS cannot predict an adoptive child’s future personality, medical issues, intellectual abilities,

appearance or inherited characteristics.

The adoptive parent(s) acknowledge that DCS has provided all non-identifying information about the child's birth parents that is known

or available to DCS.

The adoptive parent(s) acknowledge that information provided to the adoptive parent(s) by and through DCS may be incorrect or

incomplete due to the manner in which the information is obtained despite best efforts by DCS.

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| NAME OF PERSON COMPLETING THIS FORM | DATE COMPLETED |
| CSO-1067A RECEIVED BY *(Adoptive parent's signature)* | DATE |
| CSO-1067A RECEIVED BY *(Adoptive parent's signature)* | DATE |
| CSO-1067A GIVEN BY *(Child Safety Specialist signature)* | DATE |
| NAME OF PERSON DELETING OR ADDING INFORMATION *(Initial and date changes)* | DATE REVISED |
| REVISED CSO-1067A RECEIVED BY *(Adoptive parent’s signature)* | DATE |
| REVISED CSO-1067A GIVEN BY *(Child Safety Specialist signature)* | DATE |

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities

Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information

Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on

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person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language

interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other

reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you

believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability

needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office;

TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request. • Disponible en español en la oficina local.