

CONFIDENTIAL
VOLUNTARY MEDICAL BACKGROUND FORM FOR A SURRENDERED NEWBORN
 Michigan Department of Human Services

Preference for Child's Name	Date of Birth
Where was the child born?	Sex

SURRENDERING PARENT BACKGROUND (Optional)

Name	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D	Date of Birth	Phone Number
Address			
Race	Affiliated with American Indian Tribe <input type="checkbox"/> YES <input type="checkbox"/> NO	Identify Tribe	
Height	Weight	Hair Color	Eye Color
Any Family History of:	Yes	No	Yes
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Disease
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Family History of Mental Illness
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Drug Usage
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Usage
Other _____			
Surgical History			

OTHER PARENT BACKGROUND (Optional)

Name	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D	Date of Birth	Phone Number
Address			
Race	Affiliated with American Indian Tribe <input type="checkbox"/> YES <input type="checkbox"/> NO	Identify Tribe	
Height	Weight	Hair Color	Eye Color
Any Family History of:	Yes	No	Yes
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Disease
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Family History of Mental Illness
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Drug Usage
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Usage
Other _____			
Surgical History			

INFORMATION ABOUT THE PREGNANCY

Length of Pregnancy	Weight Gain Lbs.	Drug or Alcohol Use During Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes, Explain
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EMERGENCY SERVICE PROVIDER OBSERVATIONS

Comments			
ESP Signature	Date	Phone Number	
Address:	City	State	Zip Code

GENERAL INSTRUCTIONS

PURPOSE OF FORM:

The emergency service provider (ESP) is encouraged to obtain the child's family medical history with the understanding that the surrendering parent may still remain anonymous. Completion of the family medical history is **very important** for the current and future health needs of the child.

The emergency service provider should assist the surrendering parent by reading and recording information provided by the surrendering parent about the maternal and paternal family medical history.

INFORMATION ABOUT THE CHILD:

- Ask the surrendering parent if there is a preferred name for the child. If not, record Baby Boy/Girl Doe.
- Enter the child's date of birth.
- Identify the city and state where the child was born. Describe the place of birth: house, motel, etc.
- Sex of child.

PARENT INFORMATION:

- The name, date of birth, phone number and address of the surrendering or non-surrendering parent is **not** required.
- The parent should be encouraged to identify as much medical information as is known and provide details where requested.
- The parent profile information of race, height, weight, hair color and eye color is information that the child may want at a future date and should be obtained if the parent is willing to disclose.

INFORMATION ABOUT THE PREGNANCY:

- Encourage the surrendering parent to provide this minimal information about the pregnancy.

EMERGENCY SERVICE PROVIDER OBSERVATIONS:

- Record information observed or discussed with the surrendering parent.
- Sign and date.
- Provide address and phone number.

FORM DISTRIBUTION:

- Original is given to the child-placing agency for adoption planning.
- The ESP should copy and retain per agency protocols.

AUTHORITY: State P.A. 232 of 2000 RESPONSE: Voluntary PENALTY: None	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
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