



MEDICAL CONDITIONS CHECKLIST

Dear family,

As you prepare to adopt a child, there are many factors to consider. Please take your time to review each medical condition below and please share your thoughts on whether your family has capacity to parent a child with any of these medical conditions. This is meant to be a tool to discuss with your social worker throughout the adoption process.

You and your social worker should revisit this checklist as you complete your home study and during your home study update(s).

Adoptive Family Information:

Prospective adoptive parent(s) name: _____

Number of children currently in home: _____ Date of birth of the youngest child in home: _____

Adopted Child Information:

What age of child are you open to adopting? _____ to _____

Some programs require families to be open to a child of either gender. In many countries, more boys need families than girls. What gender of child would you consider adopting?

Either Male only Female only

Would you consider adopting a sibling group?

No Yes - Up to _____ children

Please list your countries of interest: _____

Behavioral and Psychological	YES	NO	MAYBE	COMMENTS:
Maladaptive aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactivity (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known history of physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known history of sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known history of neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known trauma history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attachment disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unspecified conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Birth Conditions and Prenatal Exposures	YES	NO	MAYBE	COMMENTS:
Prematurity (less than 36 weeks) *indicate # of weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low birth weight *indicate lowest birth weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Umbilical hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Failure to thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice mild/moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prenatal drug exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prenatal alcohol exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prenatal tobacco exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abandoned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
No known Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child conceived through rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child conceived through prostitution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child conceived through incest or consanguinity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Birth Family History	YES	NO	MAYBE	COMMENTS:
Family history of mental illness (e.g. schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of cognitive delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of thalassemia trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unknown birth parent information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Central Nervous System	YES	NO	MAYBE	COMMENTS:
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Microcephaly (smaller head size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocephaly (larger head size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spina bifida/meningocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brain injury *caused by trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Congenital brain malformations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypotonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures *history of or current	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Septo-Optic dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Cardiac Conditions	YES	NO	MAYBE	COMMENTS:
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASD/VSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition requiring surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition - repaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Craniofacial Conditions	YES	NO	MAYBE	COMMENTS:
Cleft lip only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cleft palate only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cleft lip and palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ankyloglossia (tongue-tied)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Plagiocephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Craniofacial conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Developmental and Cognitive	YES	NO	MAYBE	COMMENTS:
Speech delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical growth delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motor (gross and/or fine) delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
General developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Global developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech difficulty (stutter, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fetal alcohol syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Failure to thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autism (mild)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autism (moderate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autism (severe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low IQ – suspected above 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low IQ - suspected below 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory processing disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Digestive-Genital-Urinary	YES	NO	MAYBE	COMMENTS:
Gastrointestinal condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Imperforate anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genital malformation (correctible)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ambiguous genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney malfunction/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Biliary atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Genetic Conditions	YES	NO	MAYBE	COMMENTS:
Albinism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PKU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
G6PD deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hearing	YES	NO	MAYBE	COMMENTS:
Partial hearing loss, moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total hearing loss, deaf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infection (e.g. otitis media)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Slight ear deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
No physical ears *May or may not be deaf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hernias	YES	NO	MAYBE	COMMENTS:
Undescended testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circumcision male/female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hematologic Disorders	YES	NO	MAYBE	COMMENTS:
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thalassemia trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thalassemia major	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Infectious Diseases (under control)	YES	NO	MAYBE	COMMENTS:
Parasites (treated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VDRL positive (treated after delivery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis (treated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis (treated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis C carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV exposure by birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Orthopedic	YES	NO	MAYBE	COMMENTS:
Hip dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brachial plexus injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Small stature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Club foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hand or foot anomalies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arm/leg shorter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Missing arm(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Missing leg(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteogenesis Imperfecta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use of crutches/braces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheelchair confined	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrogryposis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other Conditions	YES	NO	MAYBE	COMMENTS:
History of leukemia/cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemiparesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Malnourishment/malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypo/Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Burns needing surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Progressive illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Older child (5-9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Older child (10+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Respiratory	YES	NO	MAYBE	COMMENTS:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reactive airway disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory distress syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Skin Conditions	YES	NO	MAYBE	COMMENTS:
Birthmark(s) not on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birthmark(s) on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Burn scars on hands, legs, face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tumor/abscesses – removable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Atopic eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ichthyosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision	YES	NO	MAYBE	COMMENTS:
Treatable vision issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of sight in one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision correctable w/glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision correctable w/surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Strabismus *surgically correctable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes *surgically correctable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Squint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Parent 1 Signature:

Date:

Parent 2 Signature:

Date: