Department of Health & Human Services
DHHS
NEBRASKA

Vital Statistics

NEBRASKA ADOPTION MEDICAL HISTORY (BIRTH MOTHER)

WE WISH TO OBTAIN AS COMPLETE A MEDICAL HISTORY FOR THE CHILD AS POSSIBLE. PLEASE COMPLETE ALL OF THE SECTIONS. IF THE BIRTH PARENTS, GRANDPARENTS, SIBLINGS, AUNTS OR UNCLES HAVE HAD OR NOW HAVE ANY OF THE MEDICAL CONDITIONS LISTED IN SECTION 4, PLACE A CHECK IN THE APPROPRIATE SPACE.

WHEN LISTING INFORMATION PERTINENT TO OTHER FAMILY MEMBERS, DO NOT ENTER PROPER NAMES. LIST ONLY THE RELATIONSHIP SUCH AS SISTER, UNCLE, AUNT, ETC.

IF ADDITIONAL SPACE IS NEEDED, REFER TO COMMENT SECTION ON PAGES 4 AND 4-A OR ATTACH AN ADDITIONAL SHEET.

Section 1. Birth name of child_____ Date of birth_____
Place of birth_____ City and State_____
Mother_____ Father_____

Section 2. This form is completed by_____, whose relationship to_____ is_____.

Date_____

Section 3. General State of Health of Child (Please explain, in brief, the present health of this child).

PRINTED WITH SOY INK

BIRTH MOTHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
DISEASES OF THE CIRCULATORY SYSTEM					
Rheumatic fever					
Heart trouble					
High or low blood pressure					
Stroke					
Heart attack (coronary)					
Other (specify)					
DISEASES OF THE RESPIRATORY SYSTEM					
Sinusitis					
Hay fever/other respiratory allergies					
Asthma					
Tuberculosis, emphysema					
Chronic respiratory disease					
Cystic fibrosis					
Other (specify)					
DISEASES OF THE DIGESTIVE SYSTEM					
Stomach, liver or intestines					
Gall bladder or gallstones					
Other (specify)					
DENTAL PROBLEMS					
Orthondontia					
DISEASES OF THE URINARY SYSTEM					
Kidney or bladder disorder					
Other (specify)					
DISEASES OF THE SKIN					
Eczema					
Dermatitis					
Other (specify)					
MUSCLE DISORDERS					
Muscular Dystrophy					
Muscle weakness					
Other (specify)					
DISORDER OF THE BONES/ CONNECTIVE TISSUES					
Swollen or painful joints					
Arthritis, rheumatism or bursitis					
Bone, joint or other deformity					
Scoliosis					
Open spine					
Lupus					
Other (specify)					
DISEASES OF THE NERVOUS SYSTEM					

BIRTH MOTHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
Multiple sclerosis					
Tremors					
Seizures, convulsions, epilepsy					
Other paralysis or crippling disorder					
DISORDER OF THE SENSE ORGANS					
Color blindness					
Hearing loss					
Night blindness					
Other (specify)					
DISEASES OF THE BLOOD					
Thalassemia					
Sickle cell anemia					
Anemia					
Hemophilia					
Bleeding disorder					
Other (specify)					
CANCERS					
Specify type and location, if known					
ENDOCRINE AND METABOLIC DISORDERS					
Diabetes					
Thyroid					
Phenylketonuria (PKU)					
Other hormone disorders					
Other (specify)					
BIRTH DEFECTS					
Club foot					
Heart defect					
Cleft lip or cleft palate					
Cerebral palsy					
Down syndrome					
Other deformities at birth					
Other (specify)					
INFECTIOUS DISEASES					
Sexually transmitted diseases (e.g. syphilis,					
Gonorrhea, herpes, AIDS (HIV Carrier)					
Hepatitis					
MENTAL DISORDERS					
Retardation					
Schizophrenia					
Manic depressive					
Severe depression					
Suicide					
Other (specify)					

BIRTH MOTHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
COMPLICATIONS OF PREGNANCY/ CHILDBIRTH					
Premature births, miscarriage					
Stillbirths					
Multiple births					
Infant deaths and SIDS (crib deaths)					
OTHER MISCELLANEOUS DISORDERS					
Speech					
Eating(anorexia, bulimia, etc.)					
Learning disability					
Alcoholism					
Chronic drunkenness					
Drug dependency					
Cerebral palsy					
Exposure to poisons or other chemicals Food sensitivities					

LIST ADDITIONAL COMMENTS BELOW OR ATTACH A STATEMENT

FOR COURT USE ONLY

RELEASE OF MEDICAL HISTORY

Adoption Agency/Agent_____ Date_____

Court of Jurisdiction_____ Date_____

Adoptive Parents_____ Date_____

Adoptee_____ Date_____

Bureau of Vital Statistics_____ Date_____

NEBRASKA ADOPTION MEDICAL REPORT (Birth Mother)

Section 5. Cultural History of Birth Mother

What is the Mother's Race? (May list more than one race) i.e. White, Black or African, Other

What is the Mother's Ethnicity? (May list more than one origin i.e. French, German, Irish, Spanish/Hispanic/Latina)

What is the Mother's Nationality? (City & State, Territory, or Foreign Country)

Is the Mother American Indian or Alaska Native? (List name of enrolled or principal Tribe)

Mother may include any additional Cultural History. (Social history, education achievements, personality and any other interest)

Department of Health & Human Services
DHHS
NEBRASKA

Vital Statistics

NONCONSENT BY BIOLOGICAL PARENT FOR RELEASE OF INFORMATION FOR ADOPTED PERSONS FOR WHOM RELINQUISHMENT OR CONSENT FOR ADOPTION WAS GIVEN ON OR AFTER SEPTEMBER 1,1988

Section 43-146.06, Nebraska Revised Statutes, Supplement 1988. "A biological parent may at any time file a notice of nonconsent with the bureau stating that at no time prior to his or her death may any information on the adopted person's original birth certificate or any other identifying information, except medical histories as provided in Section 43-107, be released to such adopted person. Failure by a biological parent to sign the notice of nonconsent shall be deemed a notice of consent by such parent to release the adopted person's original birth certificate to such adopted person."

INFORMATION REGARDING PERSON COMPLETING FORM

Name at time of this birth_____

_____

Present name_____

Relationship to adopted person_____

INFORMATION REGARDING ADOPTED PERSON

Name at birth _____

_____

Sex_____ Date of Birth_____

Place of Birth_____ Nebraska
(City or county)

Biological Father_____

Biological Mother_____

No information contained in the original birth certificate or any other identifying information, except medical histories as provided in section 43-107, shall be released prior to the death of the parent signing the form.

I the undersigned do understand the effects and consequences of filing, or not filing, this nonconsent form.

Signature _____

Typed or Printed Name _____

Street Address or Route Number _____

City _____ State _____ Zip _____

Telephone Number _____

Date Signed _____

Subscribed and sworn to before me this _____ day of _____ 20____

Notary Public _____

Commission Expires _____ Residing at _____

IMPORTANT NOTICE

You do not have to sign this form. If you do sign it, you are entitled to a copy of it. Your signature on this form means that the Bureau of Vital Statistics will not disclose any information contained in the original birth certificate of the adopted person or any other identifying information to any person prior to your death without a court order. If you later decide that you do not object to the release of such information, you may file a form stating that purpose.

FOR VITAL STATISTICS USE ONLY

Date received_____

By whom received_____

Vital Statistics Section
Nebraska Department of Health and Human Services
PO Box 95065
Lincoln, NE 68509-5065

Department of Health & Human Services
DHHS
NEBRASKA

Vital Statistics

NEBRASKA ADOPTION MEDICAL HISTORY (BIRTH FATHER)

WE WISH TO OBTAIN AS COMPLETE A MEDICAL HISTORY FOR THE CHILD AS POSSIBLE. PLEASE COMPLETE ALL OF THE SECTIONS. IF THE BIRTH PARENTS, GRANDPARENTS, SIBLINGS, AUNTS OR UNCLES HAVE HAD OR NOW HAVE ANY OF THE MEDICAL CONDITIONS LISTED IN SECTION 4, PLACE A CHECK IN THE APPROPRIATE SPACE.

WHEN LISTING INFORMATION PERTINENT TO OTHER FAMILY MEMBERS, DO NOT ENTER PROPER NAMES. LIST ONLY THE RELATIONSHIP SUCH AS SISTER, UNCLE, AUNT, ETC.

IF ADDITIONAL SPACE IS NEEDED, REFER TO COMMENT SECTION ON PAGES 4 AND 4-A OR ATTACH AN ADDITIONAL SHEET.

Section 1. Birth name of child_____ Date of birth_____
Place of birth_____ City and State_____
Father_____ Mother_____

Section 2. This form is completed by_____, whose relationship to_____ is_____.

Date_____

Section 3. General State of Health of Child (Please explain, in brief, the present health of this child).

PRINTED WITH SOY INK

BIRTH FATHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
DISEASES OF THE CIRCULATORY SYSTEM					
Rheumatic fever					
Heart trouble					
High or low blood pressure					
Stroke					
Heart attack (coronary)					
Other (specify)					
DISEASES OF THE RESPIRATORY SYSTEM					
Sinusitis					
Hay fever/other respiratory allergies					
Asthma					
Tuberculosis, emphysema					
Chronic respiratory disease					
Cystic fibrosis					
Other (specify)					
DISEASES OF THE DIGESTIVE SYSTEM					
Stomach, liver or intestines					
Gall bladder or gallstones					
Other (specify)					
DENTAL PROBLEMS					
Orthondontia					
DISEASES OF THE URINARY SYSTEM					
Kidney or bladder disorder					
Other (specify)					
DISEASES OF THE SKIN					
Eczema					
Dermatitis					
Other (specify)					
MUSCLE DISORDERS					
Muscular Dystrophy					
Muscle weakness					
Other (specify)					
DISORDER OF THE BONES/ CONNECTIVE TISSUES					
Swollen or painful joints					
Arthritis, rheumatism or bursitis					
Bone, joint or other deformity					
Scoliosis					
Open spine					
Lupus					
Other (specify)					
DISEASES OF THE NERVOUS SYSTEM					

BIRTH FATHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
Multiple sclerosis					
Tremors					
Seizures, convulsions, epilepsy					
Other paralysis or crippling disorder					
DISORDER OF THE SENSE ORGANS					
Color blindness					
Hearing loss					
Night blindness					
Other (specify)					
DISEASES OF THE BLOOD					
Thalassemia					
Sickle cell anemia					
Anemia					
Hemophilia					
Bleeding disorder					
Other (specify)					
CANCERS					
Specify type and location, if known					
ENDOCRINE AND METABOLIC DISORDERS					
Diabetes					
Thyroid					
Phenylketonuria (PKU)					
Other hormone disorders					
Other (specify)					
BIRTH DEFECTS					
Club foot					
Heart defect					
Cleft lip or cleft palate					
Cerebral palsy					
Down syndrome					
Other deformities at birth					
Other (specify)					
INFECTIOUS DISEASES					
Sexually transmitted diseases (e.g. syphilis,					
Gonorrhea, herpes, AIDS (HIV Carrier)					
Hepatitis					
MENTAL DISORDERS					
Retardation					
Schizophrenia					
Manic depressive					
Severe depression					
Suicide					
Other (specify)					

BIRTH FATHER

Section 4. Medical History **Health Condition**	SELF		FAMILY		COMMENTS If yes, specify which family member and indicate the date of onset, treatment, medication, etc.
	Yes	No	Yes	No	
COMPLICATIONS OF PREGNANCY/ CHILDBIRTH					
Premature births, miscarriage					
Stillbirths					
Multiple births					
Infant deaths and SIDS (crib deaths)					
OTHER MISCELLANEOUS DISORDERS					
Speech					
Eating(anorexia, bulimia, etc.)					
Learning disability					
Alcoholism					
Chronic drunkenness					
Drug dependency					
Cerebral palsy					
Exposure to poisons or other chemicals Food sensitivities					

Any other characteristics or conditions that occur in the family of either parent (Please specify condition or characteristics and the relationship)

LIST ADDITIONAL COMMENTS BELOW OR ATTACH A STATEMENT

FOR COURT USE ONLY

RELEASE OF MEDICAL HISTORY

Adoption Agency/Agent_____ Date_____

Court of Jurisdiction_____ Date_____

Adoptive Parents_____ Date_____

Adoptee_____ Date_____

Bureau of Vital Statistics_____ Date_____

NEBRASKA ADOPTION MEDICAL REPORT (Birth Father)

Section 5. Cultural History of Birth Father

What is the Father's Race? (May list more than one race) i.e. White, Black or African, Other

What is the Father's Ethnicity? (May list more than one origin i.e. French, German, Irish, Spanish/Hispanic/Latina)

What is the Father's Nationality? (City & State, Territory, or Foreign Country)

Is the Father American Indian or Alaska Native? (List name of enrolled or principal Tribe)

Father may include any additional Cultural History. (Social history, education achievements, personality and any other interest)

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Vital Statistics

NONCONSENT BY BIOLOGICAL PARENT FOR RELEASE OF INFORMATION FOR ADOPTED PERSONS FOR WHOM RELINQUISHMENT OR CONSENT FOR ADOPTION WAS GIVEN ON OR AFTER SEPTEMBER 1,1988

Section 43-146.06, Nebraska Revised Statutes, Supplement 1988. "A biological parent may at any time file a notice of nonconsent with the bureau stating that at no time prior to his or her death may any information on the adopted person's original birth certificate or any other identifying information, except medical histories as provided in Section 43-107, be released to such adopted person. Failure by a biological parent to sign the notice of nonconsent shall be deemed a notice of consent by such parent to release the adopted person's original birth certificate to such adopted person."

INFORMATION REGARDING PERSON COMPLETING FORM

Name at time of this birth_____

Present name_____

Relationship to adopted person_____

INFORMATION REGARDING ADOPTED PERSON

Name at birth _____

Sex_____ Date of Birth_____

Place of Birth_____ Nebraska
(City or county)

Biological Father_____

Biological Mother_____

No information contained in the original birth certificate or any other identifying information, except medical histories as provided in section 43-107, shall be released prior to the death of the parent signing the form.

I the undersigned do understand the effects and consequences of filing, or not filing, this nonconsent form.

Signature _____

Typed or Printed Name _____

Street Address or Route Number _____

City _____ State _____ Zip _____

Telephone Number _____

Date Signed _____

Subscribed and sworn to before me this _____ day of _____ 20____

Notary Public _____

Commission Expires _____ Residing at _____

IMPORTANT NOTICE

You do not have to sign this form. If you do sign it, you are entitled to a copy of it. Your signature on this form means that the Bureau of Vital Statistics will not disclose any information contained in the original birth certificate of the adopted person or any other identifying information to any person prior to your death without a court order. If you later decide that you do not object other release of such information, you may file a form stating that purpose.

FOR VITAL STATISTICS USE ONLY

Date received_____

By whom received_____

Vital Statistics Section
Nebraska Department of Health and Human Services
PO Box 95065
Lincoln, NE 68509-5065