NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

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).

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).

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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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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 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