

**Georgia Department of Human Resources
BACKGROUND INFORMATION FOR NON-STATE AGENCY CHILD**

Responsible Party		Telephone Number		Date
Name of Child		Date of Birth	Time of Birth	Sex
Resident County	Placement County		Race/Ethnic	

ALL RELATIONSHIPS ARE TO THE CHILD

CHILD'S NAME

CHILD'S	MATERNAL			PATERNAL		
	MOTHER	GRANDMOTHER	GRANDFATHER	FATHER	GRANDMOTHER	GRANDFATHER
DATE OF BIRTH:						
RACE / ETHNIC						
NATIONAL DESCENT:						
HAIR COLOR:						
EYE COLOR:						
COMPLEXION:						
WEIGHT:						
HEIGHT:						
OCCUPATION:						
GENERAL HEALTH:						
EDUCATION:						
IF DECEASED, AGE & CAUSE						
SPECIAL CHARACTERISTICS:						

CHILD'S MATERNAL AUNTS & UNCLES

CHILD'S PATERNAL AUNTS & UNCLES

DATE OF BIRTH:						
RACE / ETHNIC:						
NATIONAL DESCENT:						
HAIR COLOR:						
EYE COLOR:						
COMPLEXION:						
WEIGHT:						
HEIGHT:						
OCCUPATION:						
GENERAL HEALTH:						
EDUCATION:						
IF DECEASED, AGE & CAUSE:						
SPECIAL CHARACTERISTICS:						

ALL RELATIONSHIPS ARE TO THE CHILD

**SIBLINGS OF CHILD
MATERNAL**

DATE OF BIRTH:				
FULL OR HALF SIBLING:				
SEX:				
HAIR COLOR:				
EYE COLOR:				
COMPLEXION:				
GENERAL BUILD:				
GENERAL HEALTH:				
SCHOOL GRADE AND ACHIEVEMENT:				
SPECIAL CHARACTERISTICS:				

PATERNAL

DATE OF BIRTH:				
FULL OR HALF SIBLING:				
SEX:				
HAIR COLOR:				
EYE COLOR:				
COMPLEXION:				
GENERAL BUILD:				
GENERAL HEALTH:				
SCHOOL GRADE AND ACHIEVEMENT:				
SPECIAL CHARACTERISTICS:				

ALL RELATIONSHIPS ARE TO THE CHILD

FAMILY OF CHILD'S MOTHER

MATERNAL

PATERNAL

CHILD'S	GREAT GRANDMOTHER	GREAT GRANDFATHER	GREAT GRANDMOTHER	GREAT GRANDFATHER
DATE OF BIRTH:				
RACE / ETHNIC:				
NATIONAL DESCENT:				
HAIR COLOR:				
EYE COLOR:				
COMPLEXION:				
GENERAL BUILD:				
OCCUPATION:				
EDUCATION:				
IF DECEASED, AGE & CAUSE:				
SPECIAL CHARACTERISTICS:				

CHILD'S	MATERNAL GREAT AUNTS AND UNCLES	PATERNAL GREAT AUNTS AND UNCLES	
DATE OF BIRTH:			
RACE / ETHNIC:			
NATIONAL DESCENT:			
HAIR COLOR:			
EYE COLOR:			
COMPLEXION:			
GENERAL BUILD:			
OCCUPATION:			
EDUCATION:			
IF DECEASED, AGE & CAUSE:			
SPECIAL CHARACTERISTICS:			

ALL RELATIONSHIPS ARE TO THE CHILD

FAMILY OF CHILD'S FATHER

CHILD'S	MATERNAL		PATERNAL	
	GREAT GRANDMOTHER	GREAT GRANDFATHER	GREAT GRANDMOTHER	GREAT GRANDFATHER
DATE OF BIRTH:				
RACE / ETHNIC:				
NATIONAL DESCENT:				
HAIR COLOR:				
EYE COLOR:				
COMPLEXION:				
GENERAL BUILD:				
OCCUPATION:				
EDUCATION:				
IF DECEASED, AGE & CAUSE:				
SPECIAL CHARACTERISTICS:				

CHILD'S	MATERNAL GREAT AUNTS AND UNCLES		PATERNAL GREAT AUNTS AND UNCLES	
	DATE OF BIRTH:			
RACE / ETHNIC:				
NATIONAL DESCENT:				
HAIR COLOR:				
EYE COLOR:				
COMPLEXION:				
GENERAL BUILD:				
OCCUPATION:				
EDUCATION:				
IF DECEASED, AGE & CAUSE:				
SPECIAL CHARACTERISTICS:				

FAMILY MEDICAL INFORMATION MATERNAL

Click YES or NO to each of the following diseases or conditions, if the answer, is YES give family member, and brief description of disease/condition, its effect, age of onset, age if cause of death, in the space below.

	YES	NO		YES	NO		YES	NO
1. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	7. Congenital Birth Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	b) premature births	<input type="checkbox"/>	<input type="checkbox"/>
a) drugs	<input type="checkbox"/>	<input type="checkbox"/>	8. Cleft Lip	<input type="checkbox"/>	<input type="checkbox"/>	c) still births	<input type="checkbox"/>	<input type="checkbox"/>
b) foods	<input type="checkbox"/>	<input type="checkbox"/>	9. Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	d) incompetent cervix	<input type="checkbox"/>	<input type="checkbox"/>
c) asthma	<input type="checkbox"/>	<input type="checkbox"/>	10. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	e) ectopic pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
d) hay fever	<input type="checkbox"/>	<input type="checkbox"/>	11. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	f) eclamptogenic toxemia	<input type="checkbox"/>	<input type="checkbox"/>
e) other	<input type="checkbox"/>	<input type="checkbox"/>	12. Dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	g) spontaneous abortion	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcoholism/Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	13. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	h) other	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Diseases	<input type="checkbox"/>	<input type="checkbox"/>	14. Hearing Disorders	<input type="checkbox"/>	<input type="checkbox"/>	29. Respiratory Diseases	<input type="checkbox"/>	<input type="checkbox"/>
a) hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	15. Huntington Disease	<input type="checkbox"/>	<input type="checkbox"/>	a) emphysema	<input type="checkbox"/>	<input type="checkbox"/>
b) Rh disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Hyperactivity (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	b) bacterial pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
c) sickle cell disease/trait	<input type="checkbox"/>	<input type="checkbox"/>	17. Immune System Disease	<input type="checkbox"/>	<input type="checkbox"/>	c) tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
d) thalassemia (cooly's anemia)	<input type="checkbox"/>	<input type="checkbox"/>	a) HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	d) other	<input type="checkbox"/>	<input type="checkbox"/>
e) other	<input type="checkbox"/>	<input type="checkbox"/>	b) AIDS	<input type="checkbox"/>	<input type="checkbox"/>	30. Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Bone Diseases	<input type="checkbox"/>	<input type="checkbox"/>	18. Learning Disability (specify)	<input type="checkbox"/>	<input type="checkbox"/>	a) psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
a) arthritis	<input type="checkbox"/>	<input type="checkbox"/>	19. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	b) other	<input type="checkbox"/>	<input type="checkbox"/>
b) curvature of spine	<input type="checkbox"/>	<input type="checkbox"/>	20. Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	31. Speech Disorders	<input type="checkbox"/>	<input type="checkbox"/>
c) other structural malformation	<input type="checkbox"/>	<input type="checkbox"/>	a) bi-polar	<input type="checkbox"/>	<input type="checkbox"/>	a) stuttering	<input type="checkbox"/>	<input type="checkbox"/>
d) other	<input type="checkbox"/>	<input type="checkbox"/>	b) schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	b) tongue tie	<input type="checkbox"/>	<input type="checkbox"/>
5. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	c) other	<input type="checkbox"/>	<input type="checkbox"/>	c) sound omissions	<input type="checkbox"/>	<input type="checkbox"/>
a) breast	<input type="checkbox"/>	<input type="checkbox"/>	21. Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	d) sound distortions	<input type="checkbox"/>	<input type="checkbox"/>
b) bowel	<input type="checkbox"/>	<input type="checkbox"/>	a) Downs Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	e) delayed speech	<input type="checkbox"/>	<input type="checkbox"/>
c) colon	<input type="checkbox"/>	<input type="checkbox"/>	b) PKU	<input type="checkbox"/>	<input type="checkbox"/>	f) other	<input type="checkbox"/>	<input type="checkbox"/>
d) ovarian	<input type="checkbox"/>	<input type="checkbox"/>	c) Lesch-Nyham syndrome	<input type="checkbox"/>	<input type="checkbox"/>	32. Sudden Infant Death	<input type="checkbox"/>	<input type="checkbox"/>
e) skin	<input type="checkbox"/>	<input type="checkbox"/>	d) Hunters	<input type="checkbox"/>	<input type="checkbox"/>	33. Systemic Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>
f) stomach	<input type="checkbox"/>	<input type="checkbox"/>	e) tuberous sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	34. Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
g) lungs	<input type="checkbox"/>	<input type="checkbox"/>	f) other	<input type="checkbox"/>	<input type="checkbox"/>	35. Tay-Sachs Disease	<input type="checkbox"/>	<input type="checkbox"/>
h) leukemia	<input type="checkbox"/>	<input type="checkbox"/>	22. Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	36. Tourettes Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
i) other	<input type="checkbox"/>	<input type="checkbox"/>	23. Multiple Births	<input type="checkbox"/>	<input type="checkbox"/>	37. Visual Disorders	<input type="checkbox"/>	<input type="checkbox"/>
6. Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	24. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	a) cataracts	<input type="checkbox"/>	<input type="checkbox"/>
a) atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	25. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	b) dyslexia	<input type="checkbox"/>	<input type="checkbox"/>
b) congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	26. Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>	c) glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
c) heart attack	<input type="checkbox"/>	<input type="checkbox"/>	27. Obesity	<input type="checkbox"/>	<input type="checkbox"/>	d) retinitis pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>
d) hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	28. Pregnancy Complications	<input type="checkbox"/>	<input type="checkbox"/>	e) strabismus	<input type="checkbox"/>	<input type="checkbox"/>
e) stroke	<input type="checkbox"/>	<input type="checkbox"/>	a) drug/alcohol use during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	f) other	<input type="checkbox"/>	<input type="checkbox"/>
f) high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>				38. Any other diseases which have occurred repeatedly in family (specify)	<input type="checkbox"/>	<input type="checkbox"/>
g) other	<input type="checkbox"/>	<input type="checkbox"/>						

Biological Mother's age at onset of menses

Code number and letter when describing disease/condition. (attach additional page if needed)

**FAMILY MEDICAL INFORMATION
PATERNAL**

Click YES or NO to each of the following diseases or conditions, if the answer, is YES give family member, and brief description of disease/condition, its effect, age of onset, age if cause of death, in the space below.

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e) stroke	<input type="checkbox"/>	<input type="checkbox"/>	a) drug/alcohol use during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	f) other	<input type="checkbox"/>	<input type="checkbox"/>
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g) other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Code number and letter when describing disease/condition. (attach additional page if needed)

ALL RELATIONSHIPS ARE TO THE CHILD

NAMES AND ADDRESSES

NAME

DATE OF BIRTH

ADDRESS

CHILD:

MATERNAL

NAME

DATE OF BIRTH

ADDRESS

MOTHER:			
GRANDMOTHER:			
GRANDFATHER:			
AUNTS & UNCLES:			
SIBLINGS:			

PATERNAL

NAME

DATE OF BIRTH

ADDRESS

FATHER:			
GRANDMOTHER:			
GRANDFATHER:			
AUNTS & UNCLES:			
SIBLINGS:			

Is mother aware of the provision of 19-8-23(f) Reunion Registry

YES

NO

Is father aware of the provision of 19-8-23 (f) Reunion Registry

YES

NO

