

Rainbow of Love Adoption Agency, Inc.
Domestic Infant Adoption Inquiry

This application is for interest purposes only.

Date: _____

Why do you want to adopt? _____

A. Name of Prospective Adoptive Parent(s)

Name: _____
Last First/Male Middle

_____ *Last First/Female Middle*

Address: _____
Physical

_____ *City State Zip Code County*

Phone: _____
Home Business (Male) Business (Female)

Phone: _____
Cell (Male) Cell (Female) Email Address

Years Married: _____

B. Personal Data

Male		Female
	Height/Weight	
	Birth Date/Birthplace	
	Ethnic Background	
	Education Level	
	Occupation	

	Income	
	Religion	
	Health Handicap ,if any	
	Social Affiliations/Clubs	

C. Other Household Members

Name	Date of Birth	Sex	Race	Relationship (If adopted child, date of adoption)

D. Child Desired

This is a screening tool and is not intended to be binding.

I. Sex Male _____ Female _____

II. ETHNICITY (Please check all that you are open to)

___ Anglo ___ Hispanic ___ African American ___ Asian

___ Anglo / Hispanic or Asian ___ African American/Anglo or Hispanic or Asian

___ Hispanic/ Asian ___ Other (specify) _____

III. AGE RANGE

___ 0-6 months ___ 0-12months ___ 00-2yrs ___ 2-4yrs

___ 4-6 years ___ 4-12yrs ___ over 12 yrs ___ 0-18 years

Number of children that you would like to adopt? _____ "Check below"

One child only _____

Twins or siblings up to 2 _____

3 or more children _____

IV. ACCEPTABLE BACKGROUND (Y= Yes; N= No; D = Willing to Discuss)

Y	N	D	FAMILY BACKGROUND	Y	N	D	CHILD AFTER BIRTH
-	-	-	Underachievers	-	-	-	Low Apgar
-	-	-	Unknown Father	-	-	-	Premature
-	-	-	Incest	-	-	-	Failure to Thrive
-	-	-	Rape/Acquaintance Rape	-	-	-	Positive for drugs/no withdrawal
-	-	-	Retardation (Parent)	-	-	-	Addicted Child
-	-	-	Retardation (Family)	-	-	-	Minor correctible medical problem
-	-	-	Mental Illness (Parent)	-	-	-	Major correctible medical problem
-	-	-	Mental Illness (family)	-	-	-	Non-correctable handicap (mental)
-	-	-	Cancer (Parent)	-	-	-	Hearing Impairment
-	-	-	Cancer (Family)	-	-	-	Visual Impairment
-	-	-	HIV (parent)	-	-	-	Sexual Abuse
-	-	-	Dwarfism (family)	-	-	-	Legal Risk
Y	N	D	BIRTHMOTHER DURING PREGNANCY	Y	N	D	BIRTHMOTHER DURING PREGNANCY
-	-	-	No prenatal care	-	-	-	No prenatal vitamins
-	-	-	Excessive Activity or exercise	-	-	-	Sexual Abuse
-	-	-	Marijuana Use	-	-	-	Neglect
-	-	-	Cocaine or other illegal drug use	-	-	-	Homeless
-	-	-	Alcohol Usage	-	-	-	Smoking
-	-	-	Prescription Drug Use	-	-	-	HIV positive

E. Level of Openness

Rainbow of Love Adoption Agency place children in open, semi – open and closed adoptions. The birth parents at times may request some information or communication. Please indicate your interest in the following options for communicating with birthparents.

Y	N	D		Y	N	D	
-	-	-	Pre Birth Visit(s)	-	-	-	Face to Face Meeting(s)
-	-	-	Phone Call	-	-	-	Letter Exchange
-	-	-	Picture Exchange	-	-	-	Local Birthmother

F. Additional Information

1. Do you currently have an application on file with another agency? Yes No

If yes, what is the status of your application? _____

2. Have you ever applied to foster or adopt before? Yes No

If yes, when? _____

3. Were you previously married? Yes No

If yes, when? _____

4. Are you infertile? Yes No

Please explain the nature of your infertility, any testing or treatment that you have had and what your plans are for future treatment: _____

5. Have you had any physical or emotional problems in the past or are you experiencing any at the present time? Yes No (If yes, please explain)

6. Have you ever been arrested? If so, which of you, when and what was the disposition? Yes No

7. Will your family members be supportive of the adoption? Yes No

8. What are your child care plans?

9. Is there anything else that you would like us to know?

Signature (Prospective Adoptive Parent)

Signature (Prospective Adoptive Parent)