

MISSISSIPPI ADOPTION CONFIDENTIALITY ACT

Medical and Social History Purpose of and Instructions for Form 913

Mississippi State Department of Health Form 913 (Medical and Social History) is used for background information on a child adopted in the State of Mississippi on or after July 1, 1992. The original shall be part of the adoption file when it is submitted to the Vital Records Unit of the Mississippi State Department of Health.

This form is divided into three sections. Section A includes confidential information necessary for processing and filing the adoption record. Section B includes the medical history of the child and the biological family which can become critical in diagnosing and treating the child. Section C includes information of a social nature such as ancestral lines, physical characteristics, occupation and education of biological family members.

General Instructions:

1. Type or print using black ink. Only original printed forms on 25% cotton bond paper will be acceptable for filing.
2. Place the child's name as it appears on the birth certificate at the top of each page.
3. All relationships are to the child.
4. At the bottom of each page indicate the source of the information on that page, i.e. mother of child, father of child, grandmother, case files, medical records, etc.

Section A - Confidential Information

Instructions for Page 1:

Child's Birth Name: Indicate the full legal name of the child as it appears on the birth certificate.

Social Security Number: Indicate the child's social security number. If child does not have a social security number indicate NA, if the child has a number but it is unknown indicate Unk.

Sex: Indicate the sex of the child.

County of Birth: Indicate the county of birth of the child.

State File Number: Indicate the State File Number from the birth certificate.

Name and Address of Birth Family Members: Indicate the name and current address of the biological family members listed. All relationships listed are to the child. Add additional pages as necessary.

Indicate mother's and father's awareness of the provisions of the Mississippi Adoption Confidentiality Act, Section 93-17-21 et. seq.

Adopted Name: Indicate the full name of the child as it will be when the adoption is final.

Social Security Number: Indicate the child's social security number after adoption.

Child Adopted by: Indicate relationship of adoptive mother and/or adoptive father to the child.

Attorney for Adoption: Indicate the name, mailing address (include zip code) and telephone number (include area code) of the attorney responsible for handling the adoption and ensuring that this Form 913 is completed.

Adoption Agency: If an adoption agency was involved with the handling of the adoption, indicate name of adoption agency, case number, mailing address (include zip code) and telephone number (include area code).

Reason Child Placed: Indicate the reason this child is being placed for adoption.

Medical and Social History

Section A - Confidential Information

Child's Birth Name _____ Social Security Number _____

Date of Birth _____ Sex _____ County of Birth _____ State File Number _____

Family of Birth Mother	
	Name
	Address
Mother	
Grandmother	
Grandfather	
Aunts and Uncles	
Siblings	
Family of Birth Father	
Father	
Grandmother	
Grandfather	
Aunts and Uncles	
Siblings	

Are birth parents aware of the provisions of 93-17-21 et. seq. Mother yes no Father yes no

Child's adopted Name _____ Social Security Number _____

Child Adopted by <i>(check those that apply)</i>	Mother	Father		Mother	Father
Birth Parent	<input type="checkbox"/>	<input type="checkbox"/>	Other Relative of Child	<input type="checkbox"/>	<input type="checkbox"/>
Stepparent	<input type="checkbox"/>	<input type="checkbox"/>	Foster Parent of Child	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Attorney for Adoption: Agency Affiliated Independent Person

Name _____ Case Number (if applicable) _____

Address _____ Telephone _____

Adoptions Agency: Public Private Tribal

Name _____ Case Number (if applicable) _____

Address _____ Telephone _____

Reason Child Placed _____

Source of information _____

Section B - Medical History

Child's Name _____

The following is a list of diseases/conditions which may be inherited. Please identify the family member by relationship to the child e.g. child, mother, father, sibling to the child, paternal uncle, maternal grandmother etc. Give description of disease/condition, its effect, age at onset, and if cause of death, age at death.

- | | | | |
|--|---|--|---|
| <ul style="list-style-type: none"> 1. Allergies <ul style="list-style-type: none"> a. Drugs b. Foods c. Asthma d. Hay fever e. Other 2. Alcoholism/Drug Addiction 3. Blood Disease <ul style="list-style-type: none"> a. Hemophilia b. Rh Disease c. Sickle Cell Disease/Trait d. Thalassemia
(Cooley's Anemia) e. Other 4. Bone Diseases <ul style="list-style-type: none"> a. Arthritis b. Curvature of Spine c. Other Structural Malformation d. Other 5. Cancer <ul style="list-style-type: none"> a. Breast b. Bowel c. Colon d. Ovarian e. Skin f. Stomach g. Lungs h. Leukemia i. Other | <ul style="list-style-type: none"> 6. Cardiovascular Disease <ul style="list-style-type: none"> a. Atherosclerosis b. Congenital Heart Defect c. Heart Attack d. Hyperlipidemia e. Stroke f. Other 7. Congenital Birth Abnormalities 8. Cleft Lip 9. Cleft Palate 10. Cystic Fibrosis 11. Diabetes 12. Dwarfism 13. Epilepsy 14. Hearing Disorders 15. Huntington's Disease 16. Hyperactivity 17. Immune System Disease <ul style="list-style-type: none"> a. HIV Positive b. AIDS 18. Learning Disability 19. Liver Disease 20. Mental Illness <ul style="list-style-type: none"> a. Manic-Depressive b. Schizophrenia c. Other | <ul style="list-style-type: none"> 21. Mental Retardation <ul style="list-style-type: none"> a. Down's Syndrome b. PKU c. Lesch-Nyhan Syndrome d. Hunters e. Tuberous Sclerosis f. Other 22. Migraine Headache 23. Multiple Births 24. Multiple Sclerosis 25. Muscular Dystrophy 26. Myasthenia Gravis 27. Obesity 28. Pregnancy Complications <ul style="list-style-type: none"> a. Premature Births b. Stillbirths c. Incompetent Cervix d. Ectopic Pregnancies e. Eclampsyogenic Toxemia f. Spontaneous Abortion g. Other 29. Respiratory Diseases <ul style="list-style-type: none"> a. Emphysema b. Bacterial Pneumonia c. Tuberculosis d. Other 30. Skin Disorders <ul style="list-style-type: none"> a. Psoriasis b. Other | <ul style="list-style-type: none"> 31. Speech Disorders <ul style="list-style-type: none"> a. Stuttering b. Tonguetie c. Sound Omissions d. Sound Distortions e. Delayed Speech f. Other 32. Sudden Infant Death 33. Systemic Lupus Erythematosus 34. Thyroid Disorder 35. Tay-Sachs Disease 36. Visual Disorders <ul style="list-style-type: none"> a. Cataracts b. Dyslexia c. Glaucoma d. Retinitis Pigmentosa e. Strabismus f. Other 37. Any other diseases which have occurred repeatedly in family |
|--|---|--|---|

Code	Description	Effect	Family Member	Age at Onset	Cause of Death?	Age at Death
*5g	Lung Cancer (non-operable)	Disabling	Paternal grandfather	60	Yes	62

*Example
 Source of information _____

Section C - Social Information

Child's Name _____

Add additional pages as needed

	Child's Mother	Child's Grandmother	Child's Grandfather	Child's Mother's Sisters	Child's Mother's Brothers
Date of Birth					
Race/Ethnic					
National Descent					
Hair Color					
Eye Color					
Complexion					
Weight					
Height					
Occupation					
General Health					
Education					
If Deceased, Age and Cause					
Special Characteristics					

Add additional pages as needed

	Child's Father	Child's Grandmother	Child's Grandfather	Child's Father's Sisters	Child's Father's Brothers
Date of Birth					
Race/Ethnic					
National Descent					
Hair Color					
Eye Color					
Complexion					
Weight					
Height					
Occupation					
General Health					
Education					
If Deceased, Age and Cause					
Special Characteristics					

Source of information _____

Siblings of Child

Add additional pages as needed

	Other Children of Birth Mother			
	#1	#2	#3	#4
Date of Birth				
Full or Half Sibling				
Sex				
Hair Color				
Eye Color				
Complexion				
General Build				
General Health				
School Grade and Achievement				
Special Characteristics				

Add additional pages as needed

	Other Children of Birth Father			
	#1	#2	#3	#4
Date of Birth				
Full or Half Sibling				
Sex				
Hair Color				
Eye Color				
Complexion				
General Build				
General Health				
School Grade and Achievement				
Special Characteristics				

Source of information _____