

AAI
AUTUMN ADOPTIONS INC.

APPLICATION FOR POST-PLACEMENT SUPERVISION

Please complete this application by typing in your answers below and forwarding it to us along with your payment. Make all checks payable to Autumn Adoptions Inc. Please include a photo of your family, the parent narrative and any special instructions from your placement agency. You can send your pediatrician's medical report in separately. We will contact you upon receipt of this application to schedule a post placement visit and your post- placement report will be mailed to you upon completion.

TYPE OF VISIT/REPORT REQUESTED: Visit Number 1 _____

ADOPTIVE PARENT(S) CONTACT INFORMATION:

Adoptive Parent Name(s): _____

Address & Telephone No: _____

Home: _____ Street _____ City _____ State _____ Zip _____
Work (Husband): _____ Work (Wife): _____

Fax: _____ Cell or Pager: _____ Email Address: _____

GENERAL INFORMATION ABOUT YOUR ADOPTED CHILD:

Present Name of Adopted child: _____

Birth Name: _____

Birth Weight (if known) _____ Weight at Placement _____ Present Weight: _____

Birth Height (if known) _____ Height at Placement _____ Present Height: _____

Eye Color: _____ Hair Color: _____ Date of Birth/Age: _____ / _____

Placement Date: _____ Age at Placement: _____ Birth Country: _____

For China Adoptions Only:

Welfare institute/foster home (ie. Huaibei City/Anhui Province): _____

Doc. No. of "Notice of Coming to China for Adoption" _____
(Travel letter number e.g. (99) MG-4625-15-0015)

HEALTH STATUS OF YOUR CHILD AT THE TIME OF ADOPTION: (Check One)

Healthy Special Needs If special needs, please specify: _____

Is Your Child Up To Date With Immunization?: YES NO

Name of Your Child's Pediatrician: _____

Date of Most Recent Well Care Visit: _____ Date of Most Recent Sick Care Visit: _____

PLACEMENT AGENCY/ADOPTION ATTORNEY:

Name of Placement Agency: _____

Contact Person: _____ TEL: _____ FAX: _____

Adoption Attorney: _____ TEL: _____ FAX: _____

HOUSEHOLD COMPOSITION:

(List all persons living in your home, children, relatives, boarders, roommates and employees.)

Name	Birth date	Relationship	School Grade or Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Children (not living in the home): Birth Date/ Relationship/ School grade or Occupation/ Location

Signatures:

_____ **ADOPTIVE FATHER** _____ **ADOPTIVE MOTHER**

Date of Application: _____

For AAI Only: Payment Received: YES NO Date: _____ Check #/Amount: _____

Date of Post-Placement Visit: _____ Location of Post-Placement Visit: _____

Persons Present: _____

ADOPTIVE PARENT POST- PLACEMENT PARENT NARRATIVE

For First post-placement reports answer all questions below. For subsequent reports provide only new/updated information. In lieu of this narrative, you may submit an updated copy of your previous post-placement report. This form is designed so that you can type your answers directly on the form.

A. ADOPTION HISTORY: (Complete this section for the first post- placement visit only) What were the circumstances surrounding your child's adoption, for example was he abandoned, was he placed in an orphanage or foster home? Describe your adoption experience. Did you travel to another state or country for your adoption and how long did you stay?

B. HEALTH: What was your child's health status at the time of adoption? (Healthy or Special Needs) Please describe any medical treatments and the outcome. How is your child's health at present? Have your pediatrician complete the pediatrician's report and attach any medical reports received from well care or sick doctor visits along with your child's immunization record.

C. DEVELOPMENTAL MILESTONES: How is your child developing? Is he able to walk, run, sit stand? How are his fine motor skills? Is he able to hold objects, such as a crayon, and pick up objects such as cheerios? What about his speech. Is he babbling or using words? How about cognitive and social development? Do you have any concerns about your child's development?

D. TEMPERAMENT: What is your child's temperament, mood, activity level, reaction to change, etc).

E. DAILY ROUTINE/EATING, SLEEPING, AND AWAKE PATTERNS: Please describe your child's daily routine, and activities. Is he in school, or in a preschool or day care program? Describe your child's waking and sleeping patterns. What time does he go to bed? Does he sleep through the night? What are his eating habits. favorite foods and activities?

F. BONDING & ATTACHMENT: How was your child's adjustment to the home and family? Were there any issues with bonding and attachment? How was your adjustment to this placement? Describe the integration of the child into your extended family.

G. CHANGES TO THE HOME SINCE THE HOME STUDY WAS COMPLETED: Have there been any major changes in the family structure or environment following the placement of the child in the home? (E.g. job change, move, change in employment status, change in marital status, etc.)

H. NATURALIZATION & CITIZENSHIP STATUS: (International Adoption Only) Please include copies of any naturalization documents you may have i.e. Social security card, permanent resident card, US Passport.

Do you plan to re-adopt in this country? YES NO

PEDIATRICIAN'S POST- PLACEMENT MEDICAL REPORT

Please take this form to your pediatrician for completion

Child's Name: _____

Present Weight: _____ Present Height: _____ Hair Color _____ Eye Color _____

Birth Weight: (if known) _____ Birth Height (if known) _____

Parent (s) Name (s): _____

.....
(Please use a supplemental sheet when necessary)

1. List any diagnosed medical or mental condition, treatments and medications prescribed at this visit:
2. In your opinion, is this child on track developmentally and do you have any concerns for his/her continued development?
3. Is this child up to date with immunization? YES NO (If no, please explain)
4. Please list any immunizations given at this appointment and/or attach the immunization record.
5. Is this child free of communicable disease? YES NO (If not, please explain)
6. Do you have any concerns about this placement? YES NO (If yes, please explain)

Physician's Name _____ Date: _____
(Please print or Stamp)

Address: _____ Telephone: _____

Signature: _____