

GENERAL INSTRUCTIONS FOR STATE FORM 13342, INDIANA ADOPTION MEDICAL HISTORY REGISTRY

STATUTORY AUTHORITY: IC 31-19-18-3

VOLUNTARY MEDICAL INFORMATION: Any person having knowledge of the facts may voluntarily transmit medical information on this prescribed form. The contents of the report is limited to information that may affect the medical history of an adoptee.

FILING: The original copy must be filed with the State Registrar of Vital Statistics, Indiana Department of health, 2 North Meridian Street, Section B-4, Indianapolis, Indiana 46204.

COPIES: Any request for copies of this report, or any information contained in the Indiana Adoption Medical History Registry, must be directed to the State Registrar of Vital Statistics (IC 31-19-18-1).

GENERAL INSTRUCTIONS: All information on this form must be typed or printed clearly in black ink only. Please read all instructions and the definitions / examples section before starting this report.

- Please keep in mind that the person who receives this information will probably not be a physician. The medical history should be completed in the same manner that the average person would give the information to their family physician.
- Medical history information may be stated for the birth mother, birth father, birth family, and adopted person.

FOR THE PURPOSE OF THIS REPORT, THE BIRTH (BIOLOGICAL) FAMILY OF THE ADOPTED PERSON SHOULD BE LIMITED TO THEIR GRANDPARENTS AND SIBLINGS ONLY. **OTHER FAMILY MEMBERS MAY BE INCLUDED IF THE MEDICAL INFORMATION IS SIGNIFICANTLY PERTINENT TO THE MEDICAL HISTORY.**

ITEMS 1 THROUGH 6(i)

- Checkboxes are provided for the conditions stated in six (6) general areas. Each section, except allergies, includes "Other" for conditions that are applicable to that classification but not listed.
- Shaded checkboxes indicate that the condition stated is not applicable or is medically insignificant for that person or class of persons.

The medical history for the conditions stated in items 1 through 6(i) are noted first by checking the box for the persons having the history to be reported. Give additional information for each entry in the Details section.

ITEM 7 – DEATHS OF BIRTH FAMILY MEMBERS THAT MAY AFFECT THE MEDICAL HISTORY

This information should be stated as item 7 in the details section. **DO NOT REPORT DEATHS DUE TO ACCIDENT OR INJURY.**

DETAILS SECTION

Medical conditions reported are to be expanded in the Details section. Identify the condition by item number and suffix and briefly state additional information that must include the person having the history (title only) and may include the age at onset, if significant.

- CARE MUST BE TAKEN IN THE DETAILING OF MEDICAL CONDITIONS AS THE CONTENTS OF THIS REPORT CAN CONTAIN **NO INFORMATION THAT COULD LEAD TO THE IDENTIFICATION OF A PERSON.**
- PLEASE DETAIL ALL CHECKED CONDITIONS IN NUMERICAL ORDER.
- If applicable, Item 7 is reported as the last entry in this section. Be sure to include the relationship to the adopted person and the cause of death.
- If the detailing cannot be completed in the space provided, please request a supplemental details page.



INDIANA ADOPTION MEDICAL HISTORY REGISTRY

State Form 13342 (R4 / 1-24)
INDIANA DEPARTMENT OF HEALTH

INDIANA DEPARTMENT OF HEALTH

Division of Vital Records B-4
Attn: Medical History
2 North Meridian Street
Indianapolis, IN 46204

Sections A and B are CONFIDENTIAL and are for the use of the State Registrar and the Indiana Adoption Medical History registry only.
Sections A and B will never be reproduced when making a copy of the medical history.

STATE OFFICE USE ONLY

SECTION A - BIRTH INFORMATION

1. Name of child at birth (<i>first, middle, last</i>)		2. Date of birth (<i>month, day, year</i>)	3. Sex
4. Place of birth (<i>city, county, state</i>)			
5. Additional information (<i>see instructions</i>)			
6. Full maiden name of mother (<i>first, middle, last</i>)		7. Name <u>used</u> at time of birth (<i>first, middle, last</i>)	
8. Place of birth of mother (<i>state</i>)		9. Age of mother at birth of child	
10. Full name of father (<i>first, middle, last</i>)		11. Place of birth of father (<i>state</i>)	
12. Age of father at birth of child	13. Was the father married to the mother at the time of this birth? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION B - AFFIRMATION

I affirm, under the penalties for perjury, that these medical history representations are true to the best of my knowledge and belief.

14. Signature		15. Date (<i>month, day, year</i>)
16. Printed name (<i>first, middle, last</i>)		17. Relationship to the adopted child
18. Name of agency you represent (<i>if applicable</i>)		
19. Current address (<i>number and street, city, state, and ZIP code</i>)		
20. Source of medical information (<i>see instructions</i>)		

SPECIFIC INSTRUCTIONS FOR STATE FORM 13342, INDIANA ADOPTION MEDICAL HISTORY REGISTRY

SECTION A - BIRTH INFORMATION

Please complete all known items. Accurate birth facts are needed for the proper filing of the voluntary medical report being submitted. **Items 1, 2, 4, 6, and 7 must be completed.**

CHILD

ITEM

1. Enter the name (first, middle, and last) the child (adopted person) was given at birth. If the birth parent(s) did not select given names, enter the last name only.
2. Enter the month, day, and year of birth. Use the full or abbreviated name of the month (Jan., Feb., Mar., etc.). Do not use a number for the month.
3. Enter the sex of the adopted person.
4. Enter the city, county, and state of birth. If the birth did not occur in a city or town, enter only the name of the county and state.
5. Additional information - To assist in the location of the correct record, please enter the name of the hospital where the birth occurred, and any information known about the adoption placement proceedings. This includes such facts as the age when adopted, placement agency, approximate date, etc.

BIRTH MOTHER

6. Enter the full maiden name of the birth mother (first, middle, and maiden name).
7. Enter the full name USED by the birth mother when this child was born. This may be the same as her maiden name, a married name, or an assumed name.
8. Enter the state (United States) or foreign country where the birth mother was born.
9. Enter the birth mother's age at the time of this child's birth.

BIRTH FATHER

10. Enter the full maiden name of the birth father (first, middle, and last). If this information is unknown, items 10, 11, and 12 should be stated as unknown (unk.)
11. Enter the state (United States) or foreign country where the birth father was born.
12. Enter the birth father's age at the time of this child's birth.
13. Check Yes or No, or enter unknown (unk.).

SECTION B – AFFIRMATION

All items in the Affirmation section must be completed by the person supplying the medical information. IC 31-19-18-3 requires that voluntary information must include an affirmation that the information is true or that the person believes it is true.

14. The Affirmation must be signed (signature) and dated by the person providing the medical information.
15. Type or print the full name written in Item 14.
16. State your relationship (if any) to the adopted person.
17. If you represent a placement agency, law firm, etc., enter the full name of the agency (firm).
18. Enter your complete current address (number and street, city, state, and ZIP code). If your mailing address is a post Office box, the box number should be entered between the street address and the city, state, and ZIP code.
19. State the source on the medical information given (e.g., physicians records, placement agency files, personal knowledge, etc.).

