



Adoption Information Center of IL
Adoption Listing Service (ALS)
Child Registration Form

INSTRUCTIONS: Complete a separate form for each child, including each child in a sibling group. IF TPR HAS OCCURRED, include one professional, color photo; do not tape, paper clip or staple photograph to the form.

On bottom of back of photo, attach a label with the following:

1. Full name of child
2. Name of agency & worker
3. Date picture was taken
4. If sibling group picture, identify each child

Photographer Name: _____

Location photo was taken: _____

Photographer Phone Number: _____

Complete four sides of this form and mail form, CFS 600-3* & photo to:
AICI, 120 W. Madison Street, Suite 800, Chicago 60602
If questions, call 312/346-1516

CHILD'S FULL NAME: _____ Court Docket # _____

Name: _____

Birth date: _____ DCFS ID#: _____

Race/Ethnicity: _____ Gender: ☐ Male ☐ Female

Is this child being listed as part of a sibling group? ☐ Yes ☐ No

Use CFS 600-3, Consent for Release of Information form for children ages 12 and up, to consent to their mental health information appearing in the ALS Matching Book.

REGION/SITE/FIELD NUMBER: _____

PRIVATE AGENCY

Child's Worker: _____

Supervisor: _____

Agency: _____

Address: _____

City: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

E-mail: _____

DCFS OFFICE

Region/Site/Field: _____

Worker/Liaison: _____

Supervisor: _____

Address: _____

City: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

E-mail: _____

FOR AICI USE ONLY:

Listing Number:	PH _____
Age Category:	EP _____
DCFS Region:	MR _____
Adoption Listing Worker:	LD _____
Change Notice Date:	DD _____
Juvenile Court	SA _____
Photo taken:	DE _____
	HIV _____
	CO _____

CHILD'S LEGAL STATUS:

Date TPR occurred: _____

Or, if no TPR

Date passed adoption screening: _____

Or, if not passed screening

Date passed pre-screening: _____

Termination under appeal: _____

Guardianship date: _____

Other (explain) _____

CONSENT FOR ALS LISTING

DCFS GUARDIAN'S SIGNATURE

By DCFS Authorized Agent

DATE: _____

(Signature above grants consent for ALS registration only and use of child's photo if TPR has occurred.)

CONSENT FOR RECRUITMENT USING CHILD'S PHOTO, IF TPR HAS OCCURRED:

Potential Recruitment Opportunities:

- Newspaper Waiting Child Series
- TV Waiting Child Series
- Adoptive or Foster Parent Newsletters
- National Photolisting Book (CAP)
- Photolisting Web Sites
- National Adoption Exchanges

Please specify if there are any **Recruitment** opportunities listed above in which child **cannot** be featured:

Cities/Counties in which child **cannot** be featured:

If child's real name should not be used, specify name to use in recruitment: _____

DCFS GUARDIAN SIGNATURE

By DCFS Authorized Agency

DATE: _____

(Signature above grants consent for all recruitment)

ADOPTION ASSISTANCE: (Check all that apply)

☐ Monthly

☐ Conditional

☐ Medical

☐ Other

Placement History & Plans:

Date child entered substitute care: _____

Total number of placements: _____

Date entered current placement: _____

Religious preference: _____

Language(s) spoken by child: _____

Primary language: _____

Does the foster parent or a relative want to adopt this child? ☐ Yes ☐ No

Is this child available for adoptive placement with a new family? ☐ Yes ☐ No

CURRENT FOSTER PARENT INFORMATION:

Name: _____

Phone: _____

Address: _____
(Street) (City) (State & Zip)

County: _____

SIBLING INFORMATION (Use additional paper, if needed):

Names of siblings with whom child has ongoing visits: _____

Names of siblings whose goal/plan is adoption: _____

(Indicate by each child's name whether siblings must (m), should (s), should not (n), or cannot (c) be adopted with this child)

Names of siblings who are to be listed with this child: _____

Are any of these siblings twins ☐ or triplets ☐ ? (Check) Names of twins/triplets: _____

Would you consider an adoptive family that is only able to adopt part of this sibling group? ☐ Yes ☐ No

If yes, which siblings should be adopted together? _____

If no, why not? (Explain) _____

PROFILE FOR PRESPECTIVE ADOPTIVE FAMILIES BASED ON THE BEST INTERESTS OF THE CHILD:

PARENTAL PROFILE: (Check all that apply)

☐ Two-parent family

☐ Single parent

☐ Urban family

☐ Rural family

☐ IL or out-of-state family

☐ Family of specific geographic preferred* Explain _____

CHILDREN IN ADOPTIVE HOME: (Check one only)

☐ Any age

☐ Younger

☐ Older

☐ None

* Specify geographic area preferred; document how this is going to meet child's best interest. (NOTE: Section 202 of Adoption and Safe Families Act of 1997 requires states to develop plans to use cross-jurisdictional resources to effect timely adoptive placements for waiting children.)

WHAT SKILLS AND EXPERIENCE SHOULD THE FAMILY ADOPTING THIS CHILD HAVE?

EDUCATION

Child's present grade: _____ If child functioning at the appropriate grade/developmental level? ☐ Yes ☐ No

Check all that apply and indicate whether their attendance is **Full Time (FT)** or **Part Time (PT)**:

Classroom type:

- ☐ Regular _____
☐ Learning Disabled _____
☐ Behavior Disorder _____
☐ Ungraded _____
☐ Developmental _____

Special Ed services required:

- ☐ Physical therapy _____
☐ Occupational therapy _____
☐ Speech/language therapy _____
☐ Sign Language _____
☐ Early childhood 0-3 y _____
☐ Other (specify) _____

Setting:

- ☐ Public school _____
☐ Parochial _____
☐ Other private _____
☐ Residential _____
☐ Preschool/Headstart _____
☐ Pre-kindergarten _____

Indicate below any **DIAGNOSED** disabilities/conditions of this child by circling the number indicating severity:
1 = mild 2 = moderate 3 = severe

LEARNING DISABILITY**None**

- | | | |
|---|----------|---|
| 1 | Mild | Needs Resource Room help in school setting |
| 2 | Moderate | Requires several years of special education to learn to compensate |
| 3 | Severe | Requires long-term special education; will always have difficulty with one or more learning areas |

MENTAL RETARDATION**None**

- | | | | |
|---|----------|-------------------|---|
| 1 | Mild | IQ = 50-75 | Can achieve employment on an unskilled or semi-skilled level with minimum support; may be able to participate in the mainstream of community life with a job & independent living |
| 2 | Moderate | IQ = 25-50 | May work in an unskilled or semi-skilled capacity in a sheltered environment; must live in a group home or family situation where supervision is available |
| 3 | Severe | IQ = less than 25 | Must work or attend day care in a totally supervised setting; individual has some motor and speech problems; may need nursing care; limited self-care ability. |

PHYSICAL/MEDICAL CONDITIONS**None**

- | | | | | | | | |
|---|---|---|--------------------------------------|---|---|---|--------------------|
| 1 | 2 | 3 | Asthma | 1 | 2 | 3 | Hearing Impaired |
| 1 | 2 | 3 | Autism | 1 | 2 | 3 | Hydrocephalus |
| 1 | 2 | 3 | Cerebral Palsy | 1 | 2 | 3 | Muscular Dystrophy |
| 1 | 2 | 3 | Developmental Delay | 1 | 2 | 3 | Seizures |
| 1 | 2 | 3 | Down Syndrome | 1 | 2 | 3 | Sickle Cell Anemia |
| 1 | 2 | 3 | Fetal Alcohol Effect | 1 | 2 | 3 | Sickle Cell Trait |
| 1 | 2 | 3 | Fetal Alcohol Syndrome | 1 | 2 | 3 | Spina Bifida |
| 1 | 2 | 3 | Genetic Medical Conditions (Specify) | 1 | 2 | 3 | Visually Impaired |
| | | | | 1 | 2 | 3 | Other (Specify) |

Is this child Developmentally Disabled according to the following Federal definition: ☐ Yes ☐ No

DEVELOPMENTAL DISABILITY: A severe, chronic disability which is attributable to a mental and/or physical impairment; is manifested before the age of twenty-two; is likely to continue indefinitely; results in the substantial functional limitations in three or more of the following major life activities; 1) self-care; 2) receptive and expressive language; 3) learning; 4) mobility; 5) self-direction; 6) capacity for independent living; and 7) economic self-sufficiency; and reflects the person's need for a combination of special care, treatment, or other services which are lifelong or of extended duration.

EMOTIONAL/BEHAVIORAL CONDITIONS**None**

- | | | | | | | | |
|---|---|---|--|---|---|---|--------------------------------|
| 1 | 2 | 3 | Adjustment Disorder | 1 | 2 | 3 | Eating Disorder |
| 1 | 2 | 3 | Attachment Disorder | 1 | 2 | 3 | Enuresis |
| 1 | 2 | 3 | Behavior Disorder | 1 | 2 | 3 | Post Traumatic Stress Disorder |
| 1 | 2 | 3 | Childhood Anti-Social Behavior | 1 | 2 | 3 | Oppositional Defiant Disorder |
| 1 | 2 | 3 | Attention Deficit Disorder | 1 | 2 | 3 | Sexually Acts Out |
| 1 | 2 | 3 | Attention Deficit Hyperactivity Disorder | 1 | 2 | 3 | Other (Specify) |
| 1 | 2 | 3 | Compulsive Disorder | | | | |

Please answer the following:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Prenatal Drug Exposure | ☐ Yes | ☐ No |
| HIV Positive* | ☐ Yes | ☐ No |
| Diagnosed with AIDS* | ☐ Yes | ☐ No |
| Child attends counseling | ☐ Yes | ☐ No |

*Condition shall be disclosed in accordance with DCFS Rule 431, Confidentiality of Personal Information, subsection 431.100(b)(4).

I have verified that the information on this page is accurate, diagnosed and documented in the child's record and that all information on pages one and two is accurate.

Supervisor's Signature

Date

Provide a detailed description of the child including the following information (use an additional sheet, if necessary):

Personality including strengths, weaknesses & special talents:

Favorite toys/activities/hobbies/pets:

Behavior at home & school:

Overall health and medication taken, if applicable:

State positive comments the foster parent & teachers make about child:

Ability to attach and express-receive affection, counseling needs and readiness for placement: (Include need for any on-going visiting with birth family members or others.)

Ask the child what he/she would like their adoptive family to be like: (Include a quote from child, if possible.)