Status: This is the original version (as it was originally made). This item of legislation is currently only available in its original format.

SCHEDULE 3

APPENDIX 4

PART II

reports on the health of the child and of the prospective adopter(s)

Rule 4A.15(5)(b)

This information is required for reports on the health of a child and of his prospective adopter(s). Its purpose is to build up a full picture of their health history and current state of health, including strengths and weaknesses. This will enable the Board's medical adviser to base his advice to the court on the fullest possible information, when commenting on the health implications of the proposed adoption. The reports made by the examining doctor should cover, as far as practicable, the following matters.

1. The Child

Name, date of birth, sex, weight and height.

A A health history of each natural parent, so far as is possible, including: -

- (i) name, date of birth, sex, weight and height;
- (ii) a family health history, covering the parents, the brothers and sisters and the other children of the natural parent, with details of any serious physical or mental illness and inherited and congenital disease;
- (iii) past health history, including details of any serious physical or mental illness, disability, accident, hospital admission or attendance at an out-patient department, and, in each case, any treatment given;
- (iv) a full obstetric history of the mother, including any problems in the ante-natal, labour and post-natal periods, with the results of any tests carried out during or immediately after pregnancy;
- (v) details of any present illness, including treatment and prognosis;
- (vi) any other relevant information which might assist the medical adviser; and
- (vii) the name and address of any doctor(s) who might be able to provide further information about any of the above matters.
- B A neo-natal report on the child, including -
 - (i) details of the birth, and any complications;
 - (ii) results of a physical examination and screening tests;
 - (iii) details of any treatment given;
 - (iv) details of any problem in management and feeding;
 - (v) any other relevant information which might assist the medical adviser; and
 - (vi) the name and address of any doctor(s) who might be able to provide further information about any of the above matters.
- C A full health history and examination of the child, including: -
 - (i) details of any serious illness, disability, accident, hospital admission or attendance at an out-patient department, and, in each case, any treatment given;

- (ii) details and dates of immunisations;
- (iii) a physical and developmental assessment according to age, including an assessment of vision and hearing and of neurological, speech and language development and any evidence of emotional disorder;
- (iv) for a child over five years of age, the school health history (if available);
- (v) any other relevant information which might assist the medical adviser; and
- (vi) the name and address of any doctor(s) who might be able to provide further information about any of the above matters.

D The signature, name, address and qualifications of the medical practitioner who prepared the report, and the date of the report and of the examinations carried out.

2. The Applicant

(If there is more than one applicant, a report on each applicant should be supplied covering all the matters listed below.)

A (i) name, date of birth, sex, weight and height;

- (ii) a family health history, covering the parents, the brothers and sisters and the children of the applicant, with details of any serious physical or mental illness and inherited and congenital disease;
- (iii) marital history, including (if applicable) reasons for inability to have children;
- (iv) past health history, including details of any serious physical or mental illness, disability, accident, hospital admission or attendance at an out-patient department, and in each case any treatment given;
- (v) obstetric history (if applicable);
- (vi) details of any present illness, including treatment and prognosis;
- (vii) a full medical examination;
- (viii) details of any daily consumption of alcohol, tobacco and habit-forming drugs;
- (ix) any other relevant information which might assist the medical adviser; and
- (x) the name and address of any doctor(s) who might be able to provide further information about any of the above matters.

B The signature, name, address and qualifications of the medical practitioner who prepared the report, and the date of the report and of the examination carried out.