



FIRST SCHEDULE

**FORM A
THE ADOPTION OF CHILDREN ACT No. 18 of 2009**

APPLICATION FORM

PART 1. PARTICULARS OF CHILD (REN)

I (we) the undersigned desire to make application to the Childcare and Protection Agency in respect of child(ren):

Name(s) & Sex of each child:

1)..... M F 2).....M F

3)..... M F 4).....M F

Date of Birth of each child: 1)..... 2)..... 3)..... 4).....

Age of each child: 1)..... years, 2).....years, 3)..... years, 4).....years

Current address:
.....

PART 2. PARTICULARS OF APPLICANT(S)

I (We) hereby undertake that the particulars given below are true to the best of my (our) knowledge and belief.

1. **Full Name of Applicant (1):** Sex: M F

Applicant (2): Sex: M F

2. **Date(s) of Birth:**

Applicant (1): Applicant 2):

3. **Address:** Applicant (1):City:

State:

Country:

Applicant (2):City:

State:

Country:

Contact Information: Telephone: Local.....Overseas.....

Email:.....

4. **Nationality:** Applicant 1):2)

5. **Religion:** Applicant 1):2)

6. References: Names and addresses of two responsible persons who are able to vouch for the character of the applicants:-

1. Name:.....
Profession:.....
Address:

Contact Information: Telephone: Local:Overseas:.....
Email:

2. Name:
Profession:.....
Address:

Contact Information: Telephone: Local:Overseas:
Email:

“I/We have not made or attempted to make or give a payment or reward for the adoption of the above named child/children”.

“I/We was/were not coerced or manipulated and it is of my/our free will that I/we make this application”.

Signature(s):
Applicant (1):
Applicant (2):.....
Date:.....

FOR OFFICIAL USE

Case Number:
Date Received:
Interview Date:
Officer Assigned:

MEDICAL CERTIFICATE

TO BE COMPLETED BY A DULY QUALIFIED MEDICAL PRACTITIONER

APPLICANT

1. Name:

2. Address: City:

State:

Country:

3. Please describe any health problems that would affect the applicant's ability to provide for the physical and emotional needs of a child now and in the future.

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4. Is there evidence of any infectious disease liable to be contracted by the child?

5. Is there evidence of any neurotic or allied illness?

6. Does the applicant suffer from epilepsy?

7. Please comment on the applicant's general health. In your opinion, is the condition of the applicant's physical/or mental health such that he/she could be able to undertake the responsibility and perform duties of a parent?

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Signed by:.....

Qualification:

Hospital/Private Practice:

Address:

.....

Date:

(To be completed in respect of SPOUSE when a joint application is made)

1. Name:

2. Address: City:

State:

Country:

3. Please describe any health problems that would affect the applicant's ability to provide for the physical and emotional needs of a child now and in the future.

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.....
.....

4. Is there evidence of any infectious disease liable to be contracted by the child?

5. Is there evidence of any neurotic or allied illness?.....

6. Does the applicant suffer from epilepsy?

7. Please comment on the applicant's general health. In your opinion, is the condition of the applicant's physical/or mental health such that he/she could be able to undertake the responsibility and perform duties of a parent?

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Signed by:

Qualification:

Hospital/Private Practice:

Address:

.....

Date:

FORM B

PART 11
MEDICAL CERTIFICATE

TO BE COMPLETED BY A DULY QUALIFIED MEDICAL PRACTITIONER

CHILD

Name of Child:

Address:

1. State the nutritional standard of the child (good, fair, poor):

2. Is there any evidence of Syphilis or other Venereal Disease?:

State laboratory tests and their results:.....

3. Is there any evidence of Tuberculosis?:

4. Has the child ever suffered from epilepsy? If so, state nature?:

5. Is there or has there been any infection of the skin?:

6. Is there or has there been any infection of the eyes?:

7. Has the child ever had any discharge from the ears or any serious ear trouble and can he/she hear well?.....

8. Are the nose and throat in a healthy condition?:

9. Is there any evidence of disease of the heart or lung?:

10. Has the child normal control of bowels and bladder for his/ her age?:

11. Is the child suffering from any infectious or contagious disease?:

12. Has the child ever suffered from malaria, typhoid fever, measles, chicken-pox, whooping cough, diphtheria or mumps?:

13. Has the child been appropriately vaccinated?:

14. Is the child's mental or physical development normal for his/her age?:

15. Has the child any signs of active or healed rickets?:

16. Are behaviour, speech and articulation normal for his/her age?:

17. If the child has been neglected, or improperly fed, do you consider his/her condition such that if given good nursing and proper care could he/she achieve normal physical/mental development?:.....

18. Give particulars of any condition not mentioned above about which you consider an adopter should be informed:

Signed by:..... Qualification:.....

Hospital/Private Practice: Address:

Telephone: Date: