

# Waiting Child Survey

**Family Name:** \_\_\_\_\_

This is a way to help you think about your ability to accept a child with medical conditions. Mark the column which indicates, as honestly and accurately as possible, your willingness to accept a child who has:

	YES	MAYBE	NO
Albinism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birthmark/Hemangioma/Nevus (visible on face or body)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate repaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Club foot/feet or pigeon toed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease-minor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease-major	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear-partially formed or missing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extra fingers/toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss, partial/moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss, total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia (umbilical and/or inguinal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypospadias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malformation of finger/toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing fingers/toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing hand/foot/arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rickets-severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision, crossed eyes/strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision, blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision, loss of sight in one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision, roving eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Webbed fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Client Signature and Date**

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