

# Minor/Correctable Conditions Checklist – China Child of Promise Option

I/we will consider adopting a child from China with one or more of the conditions indicated below.

Name(s): \_\_\_\_\_  
 \_\_\_\_\_

Child's gender preference:

M  F  Either

Age range preference:

\_\_\_\_\_ to \_\_\_\_\_

	Yes	Maybe	No		Yes	Maybe	No		Yes	Maybe	No
<b>Birth Conditions</b>				<b>Heart</b>				<b>Skin Conditions</b>			
Cleft Lip:				Murmur, unknown prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birthmarks			
Unilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other—may require surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	requiring surgical removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(ASD, VSD, PFO, etc.)				Nevus—large or unusual raised			
Cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Infectious Diseases</b>				birthmark that may or			
Cleft lip and palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (active)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	may not be correctable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albinism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/abscesses—removable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Blood Conditions</b>				Hepatitis B active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vision</b>			
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Possible vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Central Nervous System</b>				<b>Orthopedic</b>				Loss of sight, one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral palsy:				Club foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Small stature (dwarfism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microcephaly (smaller head size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm/leg shorter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Conditions</b>			
Hydrocephaly (larger head size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rickets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please Describe:			
Spina bifida/meningocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Webbed or extra fingers, toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
<b>Digestive</b>				Congenital hip dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Anal atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brachioplexus injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
<b>Genito-Urinary-Digestive</b>				Partial or missing fingers, or hand, arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Kidney malfunction/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial or missing toes or foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Genital malformation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current or future use of crutches or braces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Vaginal atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteogenesis imperfecta (brittle bone disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
<b>Hearing</b>				Multiple orthopedic problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Partial hearing loss, moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Seizures</b>				_____			
Total hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Controlled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Ear atresia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transitory—unknown cause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			