

Nightlight Christian Adoptions Required Post Adoption 1 Month Contact Form

Adoptive Parents' Name: _____

Child's Original Name: _____

Child's Current Name: _____

Child's DOB: _____ Child Arrived Home Date: _____

Country of Origin: _____

Date and Location of this visit: _____

Describe the comfort level between the parents and the child.

Detail any appointments made for the child and the results of these visits (i.e. pediatrician, therapist, etc).

Describe any sleeping, eating, or communication issues the child is having.

Describe what action steps from the referral review the family has completed and their plan to accomplish any remaining.

Describe any parent concerns (Include any resources provided.)

Post Adoption Provider name and credentials

Name of Agency