



CIRCUIT ORPHANS' COURT FOR _____, MARYLAND
City/County

Located at _____ Case No. _____
Court Address

In the Matter of

Name of Minor Docket Reference

**ANNUAL REPORT OF GUARDIAN OF A MINOR
(Md. Rule 10-206(e))**

NOTE: Guardians of the person of minors must complete and file this form each year within 60 days of the anniversary of their appointment, or as the court otherwise directs. Attach additional sheets if needed.

If a section of this form does not apply, write "Not applicable" or "N/A."

Minor's Date of Birth: _____
Gender: Female Male

REPORTING PERIOD

I/We, _____ and (if applicable) _____,
Name of Guardian Name of Guardian 2
make this annual report for the period of _____ to _____.
Date Date

Part I. Information about the minor

A. RESIDENCE AND HOUSING

Minor's address (where he or she lives or is physically present):

Address

City, state, zip

Select all that apply:

- This is the minor's permanent residence.
- This is not the minor's permanent residence. His/Her permanent residence is located at _____,
Address City, state, zip

This is a new address (check if the minor's address changed since the last annual report or since your appointment as guardian if this is your first report).
Explain why the address changed:

Type of housing (select one):

- Own home Guardian 1's home Guardian 2's home
- Foster or boarding home Group home
- Relative's home: _____
Name of relative Relationship to minor
- Boarding School: _____
Name of school
- Hospital or medical facility: _____
Name of hospital or facility
- Residential facility: _____
Name of facility
- Other (describe): _____

Do you plan to change the place where the minor lives? Yes No

If yes, explain why:

B. MEDICAL AND PERSONAL CARE

Conditions. List significant health or mental health issues the minor has (asthma, diabetes, anxiety, etc.):

<u>Issue(s)</u>	<u>Treatment/treatment plan</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Hospitalizations. Was the minor hospitalized during the reporting period? Yes No

If yes, explain:

<u>Date</u>	<u>Hospital</u>	<u>Reason</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Providers. Which medical professional(s) did the minor see during the reporting period?

	<u>Name</u>	<u>City, state</u>	<u>Date(s) seen</u>
<input type="checkbox"/> Primary care/pediatrician	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Dentist	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Eye doctor	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Ear doctor	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Psychiatrist	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Psychologist	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Therapist (mental health)	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Physical or occupational therapist	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Speech therapist	<hr/>	<hr/>	<hr/>
<input type="checkbox"/> Other (describe):	<hr/>	<hr/>	<hr/>
	<hr/>	<hr/>	<hr/>
	<hr/>	<hr/>	<hr/>

Medications. List medications the minor takes on a regular basis:

<u>Name</u>	<u>Purpose</u>	<u>Dosage/Schedule</u>
.....
.....
.....
.....
.....

Personal care. Are there problems providing meals, clothing, housing, or transportation for the minor? Yes No

If yes, explain:

.....
.....

C. SCHOOL AND JOB TRAINING

School. Does the minor attend school? Yes No

If yes: _____
Name of school City, state, zip

Is there a care plan or an Individualized Education Program (IEP)? Yes No

If yes, did you participate in developing the care plan or IEP? Yes No

Do you believe the care plan or IEP is good or appropriate for the minor (in his or her best interest)? Yes No (explain):

.....
.....

Job training. Is the minor in a job training program? Yes No

If yes: _____
Name of program City, state, zip

Describe: _____

D. EMPLOYMENT

Does the minor have a job? Yes No

If yes: _____
Name of employer City, state, zip Hours worked per week

Type of job: _____

E. SOCIAL AND RECREATIONAL ACTIVITIES

Describe the minor's social or recreational activities during the reporting period (sports, hobbies, clubs, etc.):

.....
.....
.....
.....

F. CONTACTS

Contact with you. If the minor **does not** live with you, how often did you visit him or her during the reporting period?

.....
.....
.....

Describe your other types of contact with the minor:

Type

Frequency

- Telephone
- Mail or e-mail
- Other (describe):

Contact with others. Describe the minor’s contact with family members during the reporting period:

.....
.....
.....

G. COMMUNITY SUPPORT

List community organizations currently involved with the minor (case or care management, community services, government programs, religious programs, charitable organizations, etc.).

Organization

Services received

City, state

.....
.....
.....

Part II. Information about the guardianship

A. FUNDS

Did the guardian of the property, if any, provide funds toward the minor’s support, care, or education? Yes No Not applicable

If yes, describe (*Select all that apply*):

- clothing food housing health care (co-pays, insurance, etc.)
- transportation education extracurricular/recreational activities job training
- other (describe):

.....
.....
.....

B. HEALTH OF GUARDIAN(S)

Guardian 1 (*select one*):

- I have no serious health problems that affect my ability to serve as guardian.
- I have the following serious health problems that may affect my ability to serve as guardian:

Guardian 2 (if any) (*select one*):

- I have no serious health problems that affect my ability to serve as guardian.
- I have the following serious health problems that may affect my ability to serve as guardian:

C. CONTINUATION OF GUARDIANSHIP

This guardianship (*select one*):

- should be continued.
- should not be continued for the following reason(s):

D. POWERS OF GUARDIAN(S)

My/Our powers as guardian(s) should (*select one*):

- stay the same.
- change in the following ways for the following reasons:

E. OTHER

The court should be aware of the following matters relating to this guardianship:

I/we solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my/our knowledge, information, and belief.

_____ Date

_____ Signature of Guardian 1

_____ Printed Name

_____ Address

_____ City, state, zip

_____ Telephone

This is a new address since the last report (or since appointment if this is your first report).

_____ Date

_____ Signature of Guardian 2 (*if applicable*)

_____ Printed Name

_____ Address

_____ City, state, zip

_____ Telephone

This is a new address since the last report (or since appointment if this is your first report).