U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: xx-xx-xxxx
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

FOR CHILDREN 11 YEARS AND UNDER

PRIVACY ACT NOTICE: This information is requested pursuant to the Foreign Service Act of 1980, as amended *(22 U.S.C. 3084, 3901 and 3984)*. The primary purpose for soliciting this information is to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether federal, state, local or foreign, for law enforcement and administration purposes. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

I. To Be Filled Out By Sponsor Or Parent *(complete all sections, type or in ink).*

Date *(mm-dd-yyyy)*

1. Name of Examinee *(Last, First, MI.)*

2. Full Name of Employee/Applicant/Sponsor

3. Date of Birth *(mm-dd-yyyy)*

4. Sex ☐ Male ☐ Female

5a. Agency of Employee/Applicant/Sponsor ☐ State ☐ USAID ☐ Other _____

6. Social Security Number *(Employee/Applicant/Sponsor)*

5b. Type of Employment ☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

7. Place of Birth

City _____ State _____ Country _____

8. Post of Assignment and Dates of Departure/Arrival

a. Proposed Post _____

EDA _____ *(mm-dd-yyyy)*

b. Present Post _____

EDD _____ *(mm-dd-yyyy)*

c. Last 3 Posts _____

9. Mailing Address
(Medical Clearance Abstract will be mailed to listed address)

_____

_____

_____

Telephone Number *(where you can be reached for the next 90 days)* _____

E-mail Address *(where you can be reached for the next 90 days)* _____

10. Name of Your Health Insurance Plan

11. Purpose of Examination ☐ a. Pre-Employment ☐ b. In-Service ☐ c. Separation ☐ d. New Dependent

12. Is Child Adopted? ☐ Yes ☐ No

Check and Describe Medical Conditions of Blood Relatives. Include Sickle Cell Disease, Cancer, Alcoholism, Heart Disease, High Cholesterol, Kidney Disease, High Blood Pressure, Asthma, Mental Health Problem or Learning Disability.

☐ Father _____
☐ Mother _____
☐ Grandmother(s) _____
☐ Grandfather(s) _____
☐ Sister(s) _____
☐ Brother(s) _____
☐ Aunt(s) _____
☐ Uncle(s) _____

DO NOT WRITE IN THE SPACE BELOW *(FOR USE BY MEDICAL DIVISION ONLY)*

Clearance Action

***Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/ISS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.**

II. Have You Ever Had: | **Name of Examinee**

Yes	No		Yes	No	
☐	☐	1. Frequent or severe headaches?	☐	☐	13. Rheumatologic problems; tendon, joint or back pain/injury; bone deformity or fracture?
☐	☐	2. Dizzy spells, fainting, or seizures?	☐	☐	14. Malaria or other tropical disease?
☐	☐	3. Any neurological disorder?	☐	☐	15. Any hair, nail or skin problems or disorders?
☐	☐	4. Chronic eye trouble or vision problems? Date of last eye exam: _____	☐	☐	16. History of positive TB skin test or clinical tuberculosis/ TB exposure or BCG vaccination?
☐	☐	5. Tooth or gum problems?	☐	☐	17. Anemia or blood transfusion?
☐	☐	6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?	☐	☐	18. Recent gain or loss of 10 lbs or more?
☐	☐	7. Cough, wheezing, shortness of breath or asthma?	☐	☐	19. Frequent crying spells, trouble sleeping, sadness, withdrawal, fears, or worries?
☐	☐	8. Heart murmur or heart problems?	☐	☐	20. Difficulty in relaxing or calming down; feelings of confusion?
☐	☐	9. Rheumatic fever?	☐	☐	21. Low academic functioning or learning disability or disorders?
☐	☐	10. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?	☐	☐	22. Behavioral or discipline problems at home or school?
☐	☐	11. A change in urinary habits, urinary tract infection, bedwetting or stones, blood or protein in urine?	☐	☐	23. Have you ever been referred to or received mental health treatment?
☐	☐	12. Diabetes; thyroid or other hormonal/ metabolic disease?	☐	☐	24. Other?

III. List Current Medications *(Include prescription, over the counter, vitamins, and herbals)* | **Drug Or Other Allergies**

IV. Hospitalizations/Operations/Medical Evacuation *(Include all medical and psychiatric illnesses)*

Date *(mm-dd-yyyy)*	Illness or Operation	Name of Hospital	City and State

Anything else you would like to mention about your child's health or well being? Parent should explain "yes" answers to questions 1-24.

Please Recheck All Items for Completeness and Accuracy. DO NOT INDICATE: "Previously Answered"

The intentional omission of any crucial medical information is a criminal offense *(Section 1001 of the U.S.C. Title 18)*. Pre-employment applicants who intentionally omit information that would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause if they are hired. Current employees may also be subject to disciplinary action for intentional omission of information.

Signature of Sponsor or Parent *(I certify I have read and understand the above statements)*	Date *(mm-dd-yyyy)*

V. To Be Completed By The Examiner *(Read Section X Before Proceeding)*

Significant History *(Note: The Examiner MUST comment on ALL items checked "YES" in Part II).*

VI. To Be Completed By The Examiner | **Name Of Examinee**

1. Race *(check one)*
(need for genetic risk factors)
☐ White ☐ Black
☐ Other *(specify)* _____

2. Height
_____ in. or
_____ cm.
_____ percentile

3. Weight
_____ lb. or
_____ kg.
_____ percentile

4. Pulse *(must be recorded)*

5. Blood Pressure
(age 5 and Over)

6. Distant Vision *(age 5 and Over)*
Right 20/ Corrected 20/
Left 20/ Corrected 20/

7. Head Circumference
(18 months and under)
_____ in. or
_____ cm.

8. Development Appropriate for Age
☐ Yes ☐ No
Attach development screen if indicated under age 4

9. Immunizations Reviewed ☐ Yes ☐ No
Immunizations current? ☐ Yes ☐ No

VII. Clinical Evaluation
Check each item as indicated. Check "NE" if not evaluated.

	Normal	Abnormal	NE
1. General/Constitution			
2. Skin			
3. Eyes			
4. Ears/Nose/Throat			
5. Neck/Thyroid			
6. Lungs/Thorax			
7. Breasts			
8. Cardiovascular			
9. Abdomen			
10. Male Genitalia			
11. Anus/Rectum/Prostate			
12. Musculoskeletal			
13. Lymphatic			
14. Neurological			
15. Female Gynecologic			
16. Miscellaneous			
17. Papanicolaou done ☐ Not done ☐ Reason if not done			
18. Attach cytology report.			

Notes
(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)

Additional Comments

VIII. All Of The Following Tests Are Required Unless Otherwise Specified *(No LAB required for newborns)*

1. Hematology *(age 1 and over)*
Hematocrit _____ %

2. Urinalysis *(preemployment age 1 and over, separation and when indicated).*
Specific Gravity _____
Albumin _____
Sugar _____
WBC _____
RBC _____
Casts _____
Other _____

3. Blood Lead Level
(recommended for ages 9 mo. up to 6 years)
_____

4. Chest X-RAY *(for new TB skin test convertors, or when indicated).*
_____
Date *(mm-dd-yyyy)*
_____
Results

5. Tuberculin Test *(5TU PPD)*
recommended for all ages 1 and over, including those with previous BCG)
Date *(mm-dd-yyyy)* _____
Results _____ mm of induration
Previous BCG Yes ____ No ____
Previous Positive Yes ____ No ____
Previous Rx completed Yes ____ No ____
Date completed *(mm-dd-yyyy)* _____
New Converter *(XRay required)* Yes ____ No ____
Treatment:

6. Pre-employment Only
(or if previously not done)
a. Blood Type
ABO _____
(Rh) D _____
(weak) D^u _____
b. G6PD
Normal _____
Deficient _____

Name Of Examinee		
IX. Assessment Or Problem List	**Recommendation For Treatment/Further Study**	
Typed Name of Examiner	Signature	Date *(mm-dd-yyyy)*
Examining Facility and Telephone Number	Address	

X. Instructions to the Examiner

Disposition of Records:
All reports must be in English and identified with the full name and date of birth of the examinee.
Do Not Submit Reports by US Mail.
Do Not Submit Reports by Professional Courier Service (e.g. FedEx or DHL).
Keep originals as a permanent record.

For U.S. Department of State Health Units:
The preferred method to submit the DS-1622 is by way of eForms to Medical Records. If this is not possible, please submit the completed document by FAX.

For Private Health Care Providers:
Please FAX the completed DS-1622 directly to Medical Records.

Department of State, Medical Records:
FAX: (703) 875-5414 or (703) 875-4850

Please confirm the report was received by sending an e-mail to MedMr@state.gov