



U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102
**MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
FOR CHILDREN 11 YEARS AND UNDER**

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

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	5a. Agency of Employee/Applicant/Sponsor <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Other _____	
6. Social Security Number (Employee/Applicant/Sponsor)		5b. Type of Employment <input type="checkbox"/> Foreign Service <input type="checkbox"/> Contractor <input type="checkbox"/> 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)	
9. Mailing Address (Medical Clearance Abstract will be mailed to listed address)		b. Present Post _____ EDD _____ (mm-dd-yyyy)	
Telephone Number (where you can be reached for the next 90 days)		c. Last 3 Posts _____	
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

II. Have You Ever Had:		Name of Examinee	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Frequent or severe headaches?		13. Rheumatologic problems; tendon, joint or back pain/injury; bone deformity or fracture?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Dizzy spells, fainting, or seizures?		14. Malaria or other tropical disease?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any neurological disorder?		15. Any hair, nail or skin problems or disorders?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Tooth or gum problems?		17. Anemia or blood transfusion?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?		18. Recent gain or loss of 10 lbs or more?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Cough, wheezing, shortness of breath or asthma?		19. Frequent crying spells, trouble sleeping, sadness, withdrawal, fears, or worries?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart murmur or heart problems?		20. Difficulty in relaxing or calming down; feelings of confusion?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Rheumatic fever?		21. Low academic functioning or learning disability or disorders?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?		22. Behavioral or discipline problems at home or school?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Diabetes; thyroid or other hormonal/metabolic disease?		24. Other?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 (<i>Section 1001 of the U.S.C. Title 18</i>). 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>I certify I have read and understand the above statements</i>)			Date (mm-dd-yyyy)
V. To Be Completed By The Examiner (Read Section X Before Proceeding)			
Significant History (<i>Note: The Examiner MUST comment on ALL items checked "YES" in Part II</i>).			

VI. To Be Completed By The Examiner		Name Of Examinee		
1. Race (check one) (need for genetic risk factors) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Attach development screen if indicated under age 4	
		9. Immunizations Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No		

VII. Clinical Evaluation	Normal	Abnormal	NE	Notes (Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)
Check each item as indicated. Check "NE" if not evaluated.				
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 <input type="checkbox"/> Not done <input type="checkbox"/> Reason if not done				
18. Attach cytology report.				

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 _____ %	3. Blood Lead Level (recommended for ages 9 mo. up to 6 years) _____	5. Tuberculin Test (5TU PPD) recommended for all ages 1 and over, including those with previous BCG Date (mm-dd-yyyy) _____	6. Pre-employment Only (or if previously not done)
2. Urinalysis (preemployment age 1 and over, separation and when indicated). Specific Gravity _____ Albumin _____ Sugar _____ WBC _____ RBC _____ Casts _____ Other _____	4. Chest X-RAY (for new TB skin test convertors, or when indicated). Date (mm-dd-yyyy) _____ Results _____	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:	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 (<i>mm-dd-yyyy</i>)
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Examining Facility and Telephone Number	Address
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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