



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: 04-30-2012
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
9. Mailing Address (Medical Clearance Abstract will be mailed to listed address)		a. Proposed Post _____ EDA _____ (mm-dd-yyyy)
Telephone Number (where you can be reached for the next 90 days)		b. Present Post _____ EDD _____ (mm-dd-yyyy)
E-mail Address (where you can be reached for the next 90 days)		c. Last 3 Posts _____ _____ _____
10. Name of Your Health Insurance Plan		
11. Purpose of Examination <input type="checkbox"/> a. In-Service <input type="checkbox"/> b. Separation <input type="checkbox"/> c. New Dependent		
12. Is Child Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> 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.		
<input type="checkbox"/> Father	_____	
<input type="checkbox"/> Mother	_____	
<input type="checkbox"/> Grandmother(s)	_____	
<input type="checkbox"/> Grandfather(s)	_____	
<input type="checkbox"/> Sister(s)	_____	
<input type="checkbox"/> Brother(s)	_____	
<input type="checkbox"/> Aunt(s)	_____	
<input type="checkbox"/> Uncle(s)	_____	
13. As part of this examination, you may be asked for Family Medical History. Providing this information is strictly voluntary and will only be used for diagnosis and treatment, and only by medical providers in MED. Medical clearance decisions do not take into account Family Medical History, but only manifest diseases and medical conditions."		
_____ Signature of Parent		_____ Date (mm-dd-yyyy)

*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/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.

II. Have You Ever Had:	Name of Examinee
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Yes No

- 1. Frequent or severe headaches?
- 2. Dizzy spells, fainting, or seizures?
- 3. Any neurological disorder?
- 4. Chronic eye trouble or vision problems?
Date of last eye exam (mm-dd-yyyy) _____
- 5. Tooth or gum problems?
- 6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?
- 7. Cough, wheezing, shortness of breath or asthma?
- 8. Heart murmur or heart problems?
- 9. Rheumatic fever?
- 10. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?
- 11. A change in urinary habits, urinary tract infection, bedwetting or stones, blood or protein in urine?
- 12. Diabetes; thyroid or other hormonal/metabolic disease?

Yes No

- 13. Rheumatologic problems; tendon, joint or back pain/injury; bone deformity or fracture?
- 14. Malaria or other tropical disease?
- 15. Any hair, nail or skin problems or disorders?
- 16. History of positive TB skin test or clinical tuberculosis/ TB exposure or BCG vaccination?
- 17. Anemia or blood transfusion?
- 18. Recent gain or loss of 10 lbs or more?
- 19. Frequent crying spells, trouble sleeping, sadness, withdrawal, fears, or worries?
- 20. Difficulty in relaxing or calming down; feelings of confusion?
- 21. Low academic functioning or learning disability or disorders?
- 22. Behavioral or discipline problems at home or school?
- 23. Have you ever been referred to or received mental health treatment?
- 24. Other?

III. List Current Medications (Include prescription, over the counter, vitamins, and herbals)

Drug Or Other Allergies

<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
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IV. Hospitalizations/Operations/Medical Evacuation (Include all medical and psychiatric illnesses)

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

Is there 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) <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				Notes
Check each item as indicated. Check "NE" if not evaluated.				(Describe every abnormality in detail. Include pertinent item number before each comment.)
	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 <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

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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 and Private Health Care Providers:
 The preferred method to submit the DS-1622 is to scan and send by email to: MEDMR@state.gov.
 If it is not possible to scan, then please fax the DS-1622 to Medical Records at Fax: 703-875-4850.

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