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

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EXPIRATION DATE: 04-30-2012
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. 4084, 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. The information requested is voluntary however 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

5. Agency of Employee/Applicant/Sponsor
☐ State ☐ USAID ☐ Foreign Commercial Service
☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

6. eMED Number if known *(Employee/Applicant/Sponsor)*

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. In-Service ☐ b. Separation ☐ c. 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. The following asks questions about family medical history. Providing this information is strictly voluntary and will only be used for diagnosis and treatment, and only by providers in MED. Medical clearance decisions do not take into consideration family medical history, but only manifested medical conditions. Therefore examinee is not required to answer.

☐ a. Father _____
☐ b. Mother _____
☐ c. Grandmother(s) _____
☐ d. Grandfather(s) _____
☐ e. Sister(s) _____
☐ f. Brother(s) _____
☐ g. Aunt(s) _____
☐ h. 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**

| 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 *(mm-dd-yyyy)* _____ | ☐ | ☐ | 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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. Height | 2. Weight | 3. Pulse *(must be recorded)* | 4. Blood Pressure *(age 5 and Over)* |
|---|---|---|---|
| _____ in. or | _____ lb. or | | |
| _____ cm. | _____ kg. | | |
| _____ percentile | _____ percentile | | |

| 5. Distant Vision *(age 5 and over)* | 6. Head Circumference *(18 months and under)* | 7. Development Appropriate for Age |
|---|---|---|
| Right 20/ Corrected 20/ | _____ in. or | ☐ Yes ☐ No<br>Attach development screen if indicated under age 4 |
| Left 20/ Corrected 20/ | _____ cm. | 8. Immunizations Reviewed ☐ Yes ☐ No<br>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. Include 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:**
Parent or sponsor must sign on page 2. Medical provider must sign on page 4.
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.

If you wish to confirm that your exam forms were received please email MEDMR@state.gov.