



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. 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
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3. Date of Birth (mm-dd-yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Agency of Employee/Applicant/Sponsor <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Foreign Commercial Service
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6. eMED Number if known (Employee/Applicant/Sponsor)	<input type="checkbox"/> Foreign Agricultural Service <input type="checkbox"/> Board of Broadcasting Governors
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7. Place of Birth City _____ State _____ Country _____	8. Post of Assignment and Dates of Departure/Arrival
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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)	a. Proposed Post _____ EDA _____ (mm-dd-yyyy) b. Present Post _____ EDD _____ (mm-dd-yyyy) c. Last 3 Posts _____ _____ _____
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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																																																																														
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III. List Current Medications (Include prescription, over the counter, vitamins, and herbals)	Drug Or Other Allergies																																																																														
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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. Height _____ in. or _____ cm. _____ percentile	2. Weight _____ lb. or _____ kg. _____ percentile	3. Pulse (must be recorded)	4. Blood Pressure (age 5 and Over)
5. Distant Vision (age 5 and over) Right 20/ _____ Corrected 20/ Left 20/ _____ Corrected 20/	6. Head Circumference (18 months and under) _____ in. or _____ cm.	7. Development Appropriate for Age <input type="checkbox"/> Yes <input type="checkbox"/> No Attach development screen if indicated under age 4	
		8. 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. Include 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) _____ 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 _____
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 _____		

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	
<p>X. Instructions to the Examiner</p> <p>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.</p> <p>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.</p> <p>If you wish to confirm that your exam forms were received please email MEDMR@state.gov.</p>		