



**PRE-EMPLOYMENT 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 Agricultural Service

6. eMED Number if known (Employee/Applicant/Sponsor) Foreign Commercial Service Board of Broadcasting Governors

7. Place of Birth 8. Post of Assignment and Dates of Departure/Arrival
City _____ State _____ Country _____

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 _____
E-mail Address (where you can be reached for the next 90 days) _____ EDD _____
(mm-dd-yyyy)

10. Name of Your Health Insurance Plan

11. Purpose of Examination Pre-Employment

To the Doctor: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

| II. Have You Ever Had: | Name of Examinee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 45%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 30%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1. Frequent or severe headaches?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>13. Rheumatologic problems; tendon, joint or back pain/injury; bone deformity or fracture?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2. 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| Yes | No | | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| III. List Current Medications (<i>Include prescription, over the counter, vitamins, and herbals</i>) | | | Drug Or Other Allergies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| IV. Hospitalizations/Operations/Medical Evacuation (<i>Include all medical and psychiatric illnesses</i>) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date (<i>mm-dd-yyyy</i>) | Illness or Operation | Name of Hospital | City and State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 (<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 (<i>mm-dd-yyyy</i>) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| V. To Be Completed By The Examiner (<i>Read section X before proceeding.</i>) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. Height _____ in. or _____ cm. _____ percentile | 2. Weight _____ lb. or _____ kg. _____ percentile | 3. Pulse (<i>must be recorded</i>) | 4. Blood Pressure (<i>age 5 and Over</i>) |
| 5. Distant Vision (<i>age 5 and over</i>) Right 20/ _____ Corrected 20/ Left 20/ _____ Corrected 20/ | 6. Head Circumference (<i>18 months and under</i>) _____ 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 (<i>age 1 and over</i>) Hematocrit _____ % | 3. Blood Lead Level (<i>recommended for ages 9 mo. up to 6 years</i>) _____ | 5. Tuberculin Test (<i>5TU PPD</i>) (<i>recommended for all ages 1 and over, including those with previous BCG</i>) Date (mm-dd-yyyy) _____ | 6. Pre-employment Only (<i>or if previously not done</i>) a. Blood Type ABO _____ (Rh) D _____ (weak) D ^U _____ |
| 2. Urinalysis (<i>preemployment age 1 and over, separation and when indicated</i>) Specific Gravity _____ Albumin _____ Sugar _____ WBC _____ RBC _____ Casts _____ Other _____ | 4. Chest X-RAY (<i>for new TB skin test convertors, or when indicated</i>) 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 (<i>XRay required</i>) _____ Yes _____ No Treatment: | 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 (<i>mm-dd-yyyy</i>) |
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|---|---------|
| 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-1622P is to scan and send by email to: MEDMR@state.gov.
If it is not possible to scan, then please FAX the DS-1622P to Medical Records at Fax: 703-875-4850.

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