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-xxxxx
ESTIMATED BURDEN: 1 HOUR

PRIVACY ACT NOTICE

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. §§ 4084, 3901, 3984).

PURPOSE: The information solicited on this form will be used to make appropriate medical clearance decisions.

ROUTINE USES: The information on this form maybe shared with personnel in the Office of Medical Services. Unless otherwise protected by medical privacy regulations, the information 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. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary. However, failure to provide the information requested on this form may result in denial of a medical clearance.

PAPERWORK REDUCTION ACT STATEMENT: 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: M/MED/EX, Room L217 SA-1, U.S. Department of State, Washington, DC 20522

I. To Be Filled Out By Sponsor Or Parent *(Complete all sections, type or in ink.)*

1. Name of Examinee *(Last, First, MI.)*

Date *(mm-dd-yyyy)*

2. Full Name of Employee/Applicant/Sponsor

3. Date of Birth *(mm-dd-yyyy)*

4. Sex ☐ Male ☐ Female

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

6. Place of Birth

City _____ State _____ Country _____

7. Agency of Employee/Applicant/Sponsor

☐ State ☐ USAID ☐ Foreign Commercial Service

☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

8. 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) _____

9. 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 _____

_____

10. Purpose of Examination ☐ a. In-Service ☐ b. Separation ☐ c. New Dependent

11. Name of Your Health Insurance Plan

12. Is Child Adopted? ☐ Yes ☐ No

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**

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)*. Applicants who intentionally omit information that would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause.

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 _____ cm. _____ percentile	_____ lb. or _____ kg. _____ percentile		

5. Distant Vision *(age 5 and over)*	6. Head Circumference *(18 months and under)*	7. Development Appropriate for Age
Right 20/ Corrected 20/ Left 20/ Corrected 20/	_____ in. or _____ cm.	☐ Yes ☐ No Attach development screen if indicated under age 4

8. Immunizations Reviewed ☐ Yes ☐ No

Immunizations current? ☐ Yes ☐ No

VII. Clinical Evaluation Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	**Notes** *(Describe every abnormality in detail. Include pertinent item number before each comment.)*
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.				

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 *(if previously not done).*

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. If not previously done

a. Blood Type

ABO _____

(Rh) D _____

(weak) D^u _____

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.