



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-xxxx  
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 may be 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
5. eMED Number if known (Employee/Applicant/Sponsor)	7. Agency of Employee/Applicant/Sponsor <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Foreign Commercial Service <input type="checkbox"/> Foreign Agricultural Service <input type="checkbox"/> Board of Broadcasting Governors	
6. Place of Birth City _____ State _____ Country _____	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 _____	
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)	10. Purpose of Examination <input type="checkbox"/> a. In-Service <input type="checkbox"/> b. Separation <input type="checkbox"/> c. New Dependent	
11. Name of Your Health Insurance Plan	12. Is Child Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> 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																																																																														
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<b>III. List Current Medications</b> (Include prescription, over the counter, vitamins, and herbals)	<b>Drug Or Other Allergies</b>																																																																														
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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.																																																																															
<b>Please recheck all items for completeness and accuracy. DO NOT INDICATE: "Previously Answered"</b>																																																																															
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)																																																																												
<b>V. To Be Completed By The Examiner</b> (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 ( <i>must be recorded</i> )	4. Blood Pressure (age 5 and Over)
5. Distant Vision ( <i>age 5 and over</i> ) 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 ( <i>age 1 and over</i> ) 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. If not previously done a. Blood Type ABO _____ (Rh) D _____ (weak) D <sup>u</sup> _____
2. Urinalysis ( <i>if previously not done</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 (XRay required) _____ Yes _____ No Treatment:	

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><b>X. Instructions to the Examiner</b></p> <p><b>Disposition of Records:</b>            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><b>For U.S. Department of State Health Units and Private Health Care Providers:</b>            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>		