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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Medical Exam**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** (to be completed by program staff) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child** | Last name: | | | | | | | | | | | | First name: | | | | | | | | | | | | |
| DOB: | | | | | | | | A#: | | | | | | | | | | | Gender: | | | | | |
| **Healthcare Provider** | Name:  **MD / DO / PA / NP** | | | | | | | | | | Phone number: | | | | | | | Clinic or Practice: | | | | | | | |
| Street address: | | | | | | | | | | City or Town: | | | | | | | State: | | | | Date of visit: | | | |
| **Program** | Name of program staff with child: | | | | | | | | | | | | | | Program name: | | | | | | | | | | |
| **History and Physical** (to be completed by healthcare provider) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | | | | | | | |
| T (Co): | | | HR: | | | | BP (> 3 years): | | | | | RR: | | | | Ht (cm): | | | | | | | Wt (kg): | | |
| **Allergies** | | | | | | | | | | | | | * Check if none | | | | | | | | | | | | |
| * Food, specify: | | | | | | * Medication, specify: | | | | | | | | | | | * Other, specify: | | | | | | | | |
| **Vision** (> 5 years) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Right Eye** | | | | | | **Left Eye** | | | | | | | | | | | **Both eyes** | | | | | | |
| Corrected | | 20 / | | | | | | 20 / | | | | | | | | | | | 20 / | | | | | | |
| Uncorrected | | 20 / | | | | | | 20 / | | | | | | | | | | | 20 / | | | | | | |
| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Concerns expressed by child or caregiver: | | | | | | | | | | | | | | | | | | | | | * No concerns | | | | |
| Past medical history (include surgeries and hospital admissions): | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family History: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reproductive History: | | | | LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ or | | | | | | * N/A | | | | Previous pregnancy: G \_\_\_\_\_\_\_ P \_\_\_\_\_\_\_ or | | | | | | | | | | | * N/A |
| **Review of Systems (ROS)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all applicable signs and symptoms and enter the date each began:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| * No abnormal findings | | | | |  | | | | | | * Pain, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Fever (>37.8 Co) or chills | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Red eyes | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Runny nose | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Sore throat | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Cough | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Difficulty breathing / Shortness of breath / Wheezing | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Nausea | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Vomiting | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Diarrhea | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Neck stiffness | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Headache | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Confusion/Altered mental status | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Dizziness | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Neurologic symptoms | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Skin lesions or rash | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Yellow skin or eyes | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Swollen glands | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | * Unusual bleeding | | | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | |
| * Other 1, specify: \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Other 2, specify: \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Physical Examination** | | | | | | | | | | | | | | | | | | | | | | |
| **Check each system to indicate if normal or abnormal and describe. Leave blank if not evaluated:** | | | | | | | | | | | | | | | | | | | | | | |
| **System** | | **Normal** | | | **Abnormal** | | **Describe** | | | | | | | | | | | | | | | |
| General appearance | |  | | |  | |  | | | | | | | | | | | | | | | |
| HEENT | |  | | |  | |  | | | | | | | | | | | | | | | |
| Neck | |  | | |  | |  | | | | | | | | | | | | | | | |
| Heart | |  | | |  | |  | | | | | | | | | | | | | | | |
| Lungs | |  | | |  | |  | | | | | | | | | | | | | | | |
| GU/GYN | |  | | |  | |  | | | | | | | | | | | | | | | |
| Extremities | |  | | |  | |  | | | | | | | | | | | | | | | |
| Abdomen | |  | | |  | |  | | | | | | | | | | | | | | | |
| Back/Spine | |  | | |  | |  | | | | | | | | | | | | | | | |
| Neurologic | |  | | |  | |  | | | | | | | | | | | | | | | |
| Skin (include tattoos) | |  | | |  | |  | | | | | | | | | | | | | | | |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | |  | |  | | | | | | | | | | | | | | | |
| **Psychosocial Risk** | | | | | | | | | | | | | | | | | | | | | | |
| **In each section, place a check next to each reported condition**/**history/behavior & describe where applicable:** | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health** (Over the past 3 months) | | | | | | | | | | | | | | | * Check if no concerns | | | | | | | |
| * Feels empty, hopeless, sad, numb more often than not | | | | | | | | | | * Has trouble concentrating, restless, too many thoughts | | | | | | | | | | | | |
| * Feels constantly worried, anxious, nervous more often than not | | | | | | | | | | * Has trouble eating, sleeping | | | | | | | | | | | | |
| * Experiences mood swings, from very high to very low | | | | | | | | | | * Feels helpless | | | | | | | | | | | | |
| * Relives traumatic events from the past | | | | | | | | | | * Feels like hurting others | | | | | | | | | | | | |
| * Feels easily annoyed or irritated | | | | | | | | | | * Feels like hurting self, would be better off dead | | | | | | | | | | | | |
| * Feels afraid, easily startled, jumpy | | | | | | | | | | * Other concerns: | | | | | | | | | | | | |
| **Physical Abuse History** | | | | | | | | | | | | | * Check if physical abuse is denied | | | | | | | | | |
| * Victim of physical abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | * In home country | | | | * During journey to U.S. | |
| * In US, not in ORR custody | | | | * In ORR custody | |
| **Sexual Activity/Abuse History** | | | | | | | | | | | | | | * Check if sexual activity or abuse are denied | | | | | | | | |
| * Consensual sexual activity (oral/vaginal/anal) | | | | | | | | | | | | | | | | | | | | | | |
| * Sexual abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | * In home country | | | | * During journey to U.S. | |
| * In US, not in ORR custody | | | | * In ORR custody | |
| * Previous STD diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| **Substance Use** | | | | | | | | | | | * Check if substance use is denied | | | | | | | | | | | |
| * IVDU: | | | * Alcohol: | | | | | | * Tobacco: | | | | | | | | | | * Other: | | | |
| **Laboratory Testing** | | | | | | | | | | | | | | | | | | | | | | |
| **Ordered** | **Test** | | | **Indicators** | | | | | | | | | | | | **Result** | | | | | | |
| **Positive** | | | | **Negative** | | **Indeterminate** |
|  | Flu, rapid | | | Fever + cough or sore throat | | | | | | | | | | | |  | | | |  | |  |
|  | HIV | | | > 13 yrs or Sexual activity/abuse | | | | | | | | | | | |  | | | |  | |  |
|  | Pregnancy | | | >10 yrs or Sexual activity/abuse | | | | | | | | | | | |  | | | |  | |  |
|  | Lead **(positive >5** **mcg/dl)** | | | 6 mos - 6 yrs | | | | | | | | | | | |  | | | |  | |  |
|  | Hepatitis B surface antigen | | | Sexual activity/IVDU | | | | | | | | | | | |  | | | |  | |  |
|  | Hepatitis C antibody | | | IVDU | | | | | | | | | | | |  | | | |  | |  |
|  | Syphilis RPR/VRDL | | | Sexual activity/abuse | | | | | | | | | | | |  | | | |  | |  |
|  | Chlamydia NAAT | | | Sexual activity/abuse | | | | | | | | | | | |  | | | |  | |  |
|  | Gonorrhea NAAT | | | Sexual activity/abuse | | | | | | | | | | | |  | | | |  | |  |
| **TB Screening** (Use Supplemental TB Screening form for result documentation) | | | | | | | | | | | | | | | | | | | | | | |
| Has child ever been a close contact to someone with ***active*** TB disease? | | | | | | * No | | * Yes, specify: | | | | | | | | | | | | | | |
| Has child ever been treated for ***active*** TB disease? | | | | | | * No | | * Yes, specify: | | | | | | | | | | | | | | |
| Has child ever been treated for ***latent*** TB infection? | | | | | | * No | | * Yes, specify: | | | | | | | | | | | | | | |
| **TB screening method ordered:** | | | | * TST | | | | * IGRA | | | | * CXR | | | | | | * Was or will be tested elsewhere | | | | |

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| **Assessment and Plan** | | | | | |
| **Assessment:** | Child without complaints, symptoms, diagnoses/conditions; no meds (including OTC) or referrals needed: | | | * No | * Yes |
| If No, check all diagnoses that apply. If “Other” is selected, specify in the space provided. | | | | | |
| **General/Constitutional**   |  |  | | --- | --- | | * Allergy (e.g., drug reaction, food allergy),   specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Dehydration | * Malnourished | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **HEENT**   |  |  | | --- | --- | | * Headache/Migraine | * Hearing issues | | * Otitis media/Ear infection | * Pharyngitis (Not strep throat) | | * Rhinitis | * Strep throat | | * Vision issues | * Viral/Bacterial Conjunctivitis | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |   **Respiratory/Pulmonary**   |  |  | | --- | --- | | * Asthma | * Influenza-like illness (ILI) | | * Influenza, lab-confirmed; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Upper/lower respiratory illness; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Cardiovascular**   |  |  | | --- | --- | | * Heart murmur | * Syncope/fainting | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Gastrointestinal**   |  |  | | --- | --- | | * Abdominal pain | * Gastroenteritis | | * Heartburn/reflux | * Intestinal parasites | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Genito-urinary/Reproductive**   |  |  | | --- | --- | | * Childbirth | * Pregnancy/Pregnancy-related | | * Genital warts | * Urinary tract infection | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Neurological**   |  |  | | --- | --- | | * Developmental delay | * Seizure/epilepsy | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Musculoskeletal**   |  |  | | --- | --- | | * Back pain | * Fracture | | * Leg pain | * Sprain/Strain | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | **Skin, Hair, and Nails**   |  |  | | --- | --- | | * Cellulitis | * Dermatitis/Rash (not acne) | | * Ingrown toenail | * Lice | | * Scabies | * Tinea pedis | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Potentially Reportable Infectious Disease**   |  |  | | --- | --- | | * Acute hepatitis A | * Acute/chronic hepatitis B | | * Acute/chronic hepatitis C | * Chikungunya | | * Chlamydia | * Dengue | | * Gonorrhea | * HIV | | * Malaria | * Measles | | * Mumps | * Pertussis | | * Rubella | * Sepsis/Meningitis | | * Syphilis | * TB | | * Typhoid fever | * Varicella | | * Viral hemorrhagic fever, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Zika virus |  * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Abuse**   |  | | --- | | * Sexual; where/when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Physical; where/when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  * **Other, Medical:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Behavioral and Mental Health Concerns**   |  |  | | --- | --- | | * ADHD/ADD | * Adjustment disorder | | * Anxiety disorder | * Bipolar disorder | | * Borderline personality disorder | * Depressive disorder | | * Panic disorder | * PTSD | | * Schizophrenia | * Self-injury/cutting | | * Suicide ideation/attempt | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Plan:** Check all that apply and specify in the space provided. | | | | | |
| Return to clinic:   * PRN/As needed | | * Follow-up (specify condition, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| * Referred to specialist/counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * Prolonged treatment/therapy (e.g., physical therapy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * New/Current medications (specify name, reason, date started, dose, and directions and indicate if psychotropic): | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * Immunizations given/validated from foreign record * List immunizations not given due to medical contraindication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * Age-appropriate anticipatory guidance discussed and/or handout given | | | | | |
| * Child quarantined/isolated at the program for a diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * Release of child delayed from the program because of a diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Page 3 of 4  ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Additional Information** | | | | | |
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| **Potentially Reportable Infectious Diseases** | | | |
| Lab testing performed to confirm the diagnosis: | * No | * Yes | |
| Health department notified by program: | * No | * Yes | * Not applicable |
| Intakes delayed/postponed because of this diagnosis: | * No | * Yes | |
| UAC exposed to this child while infectious: | * No | * Yes (Complete a Contact Investigation Form for each exposed UAC) | |
| Number of staff members exposed to this diagnosis: |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Potentially Reportable Infectious Disease (Non-TB) Lab Testing** | | | | |
| **Disease Tested** | **Collection Date** | **Specimen Type (e.g., Serum)** | **Test Type (e.g., IgM)** | **Result** |
|  |  |  |  |  |
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|  |  |  |  |  |

Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

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