**OFFICE OF REFUGEE RESETTLEMENT**

**Division of Children’s Services**

**MEDICAL CHECKLIST FOR INFLUX TRANSFERS**

|  |  |  |  |
| --- | --- | --- | --- |
| IDENTIFYING INFORMATION | | | |
| UC’s Name:  A#: | Completed By (name and title):  Date Completed: | | |
| INSTRUCTIONS | | | |
| * This checklist should be completed by a medical coordinator or other medical staff no later than 24 hours prior to the proposed transfer date. * **If “No” is checked for any of the below questions, do not transfer the child to an influx care facility.** * The completed checklist should be uploaded to the UC Portal and the paper copy stored in a secure location. Do not include a copy of this checklist with the child’s transfer documents as it contains confidential medical information. * The person completing this form should initial the *Care Provider Checklist for Transfers to Influx Care Facilities* to indicate the child is medically cleared and vaccinated. | | | |
| CHECKLIST | | | |
|  | | Meets Influx Transfer Criteria | Does Not Meet Influx Transfer Criteria |
| Has the initial medical exam been completed? | | Yes | No |
| Have results from all lab tests (e.g., STD tests) and medical consultations been received? | | Yes | No |
| TB screening | |  |  |
| Does the child have a negative PPD (<10 mm) or IGRA? | | Yes | No |
| For 15-17 year olds, does the child have a normal chest X-ray? | | Yes  NA[[1]](#footnote-1) | No |
| HIV screeningWas the child tested for HIV? *Check “No” if child opted out of HIV testing.*  * 1. If the child was tested, was the HIV test negative? | | Yes Yes | No No |
| 1. For females, was the pregnancy test negative? | | Yes  NA1 | No |
| 1. Did the child receive the following immunizations? | |  |  |
| * 1. Tdap (tetanus, diphtheria, pertussis) | | Yes | No |
| * 1. Hepatitis A | | Yes | No |
| * 1. Hepatitis B | | Yes | No |
| * 1. Varicella (chickenpox) | | Yes | No |
| * 1. IPV (inactivated poliovirus vaccine) | | Yes | No |
| * 1. MMR (measles, mumps, rubella) | | Yes | No |
| * 1. MCV4 (meningococcal disease) | | Yes | No |
| * 1. HPV (human papillomavirus) | | Yes | No |
| * 1. Flu, when seasonably available (generally, September through June) | | Yes  NA1 | No |
| 1. Did the child receive all of the above immunizations more than 72 hours before the scheduled physical transfer? | | Yes | No |
| Is the child currently clear of all contagious conditions, including scabies and lice?[[2]](#footnote-2) | | Yes | No |
| Have you confirmed the child has no known medical or dental issues requiring additional evaluation, treatment, or monitoring by a healthcare provider? | | Yes | No |
| Has a clinician confirmed the child has no known mental health issues requiring additional evaluation, treatment, or monitoring? **Clinician, please initial here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | Yes | No |
| Has the following documentation been uploaded to the Files section of the Portal Health Tab: Initial Medical Exam form, Supplemental TB Screening form, lab results, immunization record, and chest x-ray reading (for 15-17 year olds)? | | Yes | No |

1. *NA: Question is not applicable (i.e., child is <15 years; pregnancy testing for males; flu vaccine is not seasonably available).* [↑](#footnote-ref-1)
2. *A lice, fever, and rash check will also be done within 24 hours of physical transfer, per the ORR Operations Guide, Section 1.2.10.* [↑](#footnote-ref-2)