U.S. Department of State
Bureau of Medical Services, M/MED, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION
FOR CHILDREN AGE 11 AND YOUNGER

PRIVACY ACT NOTICE
AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (Title 22 U.S.C.4084).
PURPOSE: The information solicited from this form will assist in making a medical clearance decision for individuals eligible to participate in the Department of State Medical Program while assigned abroad. (16 FAM 100 - 200)
ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. More information on routine uses can be found in the System of Records Notice State-24, Medical Records.
DISCLOSURE: Providing this information is voluntary; however, not providing requested information may result in the failure of the individual to obtain the requisite medical clearance pursuant to 16 FAM 211.

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 recommendation for reducing it, please send them to: M/MED/EX, Room L101 SA-1, U.S. Department of State, Washington, DC 20522

I. DEMOGRAPHIC INFORMATION
TO BE FILLED OUT BY EMPLOYEE/SPONSOR OR PARENT

DATE OF EXAM *(mm-dd-yyyy)*

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

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

3. Sex ☐ Male ☐ Female

4. Full Name of Employee/Applicant/Sponsor

5. MED Number if known (*C*hild examinee)

6. Place of Birth

City _____ State _____ Country _____

7. Agency of Employee/Applicant/Sponsor

☐ STATE ☐ USAID ☐ FCS ☐ FAS ☐ U.S. Agency for Global Media ☐ DoD Civilian ☐ DoD Contractor

☐ Non-Foreign Service Agency _____ ☐ Contracting Company _____

8. E-mail Address of Parent/Sponsor
(Where You can be Reached for the Next 90 days)

Primary: _____

Alternate: _____

9. Purpose of Exam

☐ New Dependent (*pre-employment, newborn, adoption*)

☐ In-Service Exam

☐ Separation

10. Telephone Number of P*arent/Sponsor*
(Where You can be Reached for the Next 90 days)

Primary: _____

Alternate: _____

11. Post of Assignment and Estimated Dates of Arrival / Departure

a. Proposed Post _____ EDA _____ *(mm-dd-yyyy)*

b. Present Post _____ EDD _____ *(mm-dd-yyyy)*

To the individual and/or health care provider completing the medical history review /exam: 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 members' 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.

Name of Examinee	DOB

II. MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS: ALL YES ANSWERS MUST HAVE A WRITTEN EXPLANATION WITH DATE OF OCCURENCE IN BOX IIA.

Does your child currently, or have a hisory of:

Yes	No		
☐	☐	1.	Frequent/severe headaches?
☐	☐	2.	Fainting, dizzy episodes, or syncope?
☐	☐	3.	Seizures or neurologic disorders?
☐	☐	4.	Eye or vision problems?
☐	☐	5.	Ear, nose, or throat problems, including hearing loss?
☐	☐	6.	Allergies or history of anaphylactic reaction?
☐	☐	7.	Cough, wheeze, shortness of breath, asthma?
☐	☐	8.	Murmurs, palpitations, or other heart problems?
☐	☐	9.	Rheumatic fever?
☐	☐	10.	Diabetes, thyroid, or other endocrine disorders?
☐	☐	11.	Hormonal or metabolic disorder?
☐	☐	12.	Stomach, esophageal, or other intestinal problems?
☐	☐	13.	Jaundice, hepatitis, gallbladder or other liver disease?
☐	☐	14.	Intestinal, rectal problems or hernia?
☐	☐	15.	Anemia?
☐	☐	16.	Blood transfusions?
☐	☐	17.	Urinary or kidney problems, blood in urine?
☐	☐	18.	Cancer of any type?
☐	☐	19.	Premature birth, pre or post-natal complications?

Yes	No		
☐	☐	20.	Joint, tendon or any orthopedic disorder?
☐	☐	21.	Rheumatologic or immune disorder?
☐	☐	22.	Malaria, tropical or other infectious disease?
☐	☐	23.	Any recent unexpected weight loss/gain?
☐	☐	24.	Any skin or nail disorder
☐	☐	25.	History of positive TB skin test, IGRA, or Tuberculosis?

Yes	No		
☐	☐	25.	Has your child been referred for any current or potential special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)?
☐	☐	26.	In the past seven years, has your child been in psychotherapy/counseling or been prescribed medication to help with depression, anxiety, mood or stress?
☐	☐	27.	Has your child felt unusually depressed, sad, blue, or had frequent crying spells which lasted more than 2 weeks at a time, within the past seven years?
☐	☐	28.	In the past seven years, has your child had frequent or recurrent episodes of: difficulty relaxing or calming down, panicky feelings, irritability, anger, feeling hyper, or nervousness?
☐	☐	29.	In the past seven years, has your child experienced any emotional or physical symptoms related to a past trauma?

30. Is there anything else you would like to add about your child's health or well being that was not addressed in questions 1-29? ☐ Yes ☐ No

II a. Explanation required for "yes" answers to questions 1-30. Attach additional sheets as needed

III. LIST OF CURRENT MEDICATIONS *(Include prescription, over the counter, vitamins, and herbs)*	**Drug Or Other Allergies**

IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS *(Include all medical and psychiatric illnesses)*

Date *(mm-dd-yyyy)*	Illness or Operation	Name of Hospital	City and State

Any knowing and willful omission, falsification, or fraudulent statement regarding material medical information may constitute a criminal offense under 18 U.S.C. § 1001, and individuals committing such an offense may be subject to criminal prosecution. Employees of the United States Government also may be subject to disciplinary action, up to and including separation, for any knowing and willing omission or falsification or fraudulent statement of material information.

V. SIGNATURE OF PARENT OR SPONSOR *(I certify I have read and understand the above statement.)*

	Date *(mm-dd-yyyy)*

Name of Examinee	DOB

VI. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DS-1622

MEDICAL EXAMINER

- Medical Examiner must comment on positive history (pg. 2), abnormal physical findings (pg. 3), and provide follow-up recommendations (pg. 4).
- Medical Examiner must sign on page 4.

EMPLOYEE SPONSOR / PARENT

- All fields on page 1 and 2 must be filled out. Examinee or parent/employee sponsor must sign on page 2.
- Submit copies of all laboratory tests and additional medical reports with DS-1622.
- All Lab tests and medical reports must be in English, and identified with full name and date of birth of examinee.
- Keep originals as a permanent record. Do NOT submit by U.S. Mail or by courier service (e.g. FedEx or DHL).

Submit the DS-1622 and other documentation via email in PDF format to MEDMR@state.gov (preferred), or by fax to the Medical Records Department at 202-647-0292. If you wish to confirm that your exam forms were received, email MEDMR@state.gov.

VII. Medical Examiner comments on significant patient medical history and items checked "yes" on page 2 / section II. Use additional pages if needed.

VIII. CLINICAL EVALUATION: *Newborn exam cannot be accepted if completed before four (4) weeks of age*

1. Height/Length	2. Weight	3.Pulse or HR (REQUIRED FOR ALL AGES and NEWBORNS) RECORD	4. Blood Pressure *(age 3 and Over)*
_____ in. or _____ cm. _____ percentile	_____ lb. or _____ kg. _____ percentile		

5. Head Circumference *(18 months and under)*	6. Development Appropriate for Age ☐ Yes ☐ No If NO, attach Development Screen and explain below with detail in assessment / plan
_____ in. or _____ cm. _____ percentile	7. Gestational age at birth
	8. Immunizations Reviewed ☐ Yes ☐ No Immunizations current? ☐ Yes ☐ No

IX. PHYSICAL EXAM Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	Notes *(Describe each abnormality in detail. Include pertinent item number before each comment)*
1. General/Constitution				
2. Development				
3. Skin				
4. Eyes				
5. Ears/Nose/Throat				
6. Neck/Thyroid				
7. Lungs/Thorax				
8. Cardivascular (*Record murmurs/abnormalities*)				
9. Abdomen				
10. Genitalia				
11. Anus/Rectum				
12. Musculoskeletal/Spine/ Extremities (*Note limitations*)				
13. Lymph nodes				
14. Neurologic				

Name of Examinee	DOB

X. LABORATORY ANALYSIS

NO LABORATORY TESTS REQUIRED FOR INFANTS

For ages 1 year and above, all tests are required unless otherwise specified. Results from previous 12 months are acceptable.

COPIES OF LABORATORY REPORTS MUST BE SUBMITTED FOR REVIEW AND MUST BE IN ENGLISH

1. Hematology *(age 1 and over)*

Hematocrit _____ % **OR** Hemoglobin _____ gms%

2. Tuberculin Skin Test : **REQUIRED** *for ages 1 and over (unless previously positive)*
For baseline status in a child who will live overseas in a likely endemic TB area.

TST Results: _____ mm of induration Date: _____

IGRA Results: _____ Date: _____

Interferon Gamma Release Array: (may substitute for TST if > 5 y/o or In those with previous BCG)

Previous active tuberculosis ☐ Yes ☐ No Date: _____

Previous positive TST or IGRA ☐ Yes ☐ No Date: _____

Previous LTBI treatment ☐ Yes ☐ No Date: _____

Hx of BcG vaccine ☐ Yes ☐ No Date: _____

3. Chest X Ray *(PA and lateral)* **- Required only if TST > 10mm, positive IGRA or clinically indicated.**

Results: _____

Date: _____

OPTIONAL TESTS*:* The following test are not required for a medical clearance determination. The expense of performing these exams is not routinely authorized. The tests may be performed at the clinical discretion of the examiner with patient consent. If performed or previous results are available, the results may be used by the Department of State in a medical clearance determination and future clinical care of individuals covered under the Department's Medical Program.

4. Blood Type *(if not previously documented)* Type: ABO _____ (Rh) Dμ: _____ (weak D): _____

5. G6PD *(If not previously documented)* for malarial prophylaxis Results: _____ Date: _____

6. Blood lead level *(recommended screening ages 12 months to 5 years)* Results: _____ Date: _____

XI. Assessment or Problem List	XII. Recommendation for Treatment / Further Study / Consultation or Follow - Up

NOTICE: This form is not complete until all laboratory tests and results from section X are attached and included with this DS-1622 form.

Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
Address	Telephone Number	