

Health Assessment Form Unaccompanied Children's Program Office of Refugee Resettlement (ORR)

General Information

Minor	Last name:		First name:			
	DOB:		A#:	Gender:		
Healthcare Provider (HCP)	Name: MD / DO / PA / NP		Clinic/Practice:		Specialty Type:	
	Street address:		City or Town:		State:	Phone number:
	Location where child received care (e.g., Offsite clinic, ER):					Date evaluated:
Program	Program name:		<input type="checkbox"/> Program Staff Member Present During Exam with HCP			

History and Physical Assessment

Vital Signs

Temperature (T)	Heart Rate (HR)	BP (≥ 3 yrs)	Resp Rate (RR)	Height (HT)	Weight (WT)	BMI (≥2 yrs)	BMI %ile
F / C				in / cm	lbs / kg		

Allergies: No Yes, specify below

Allergen	Food	Medication	Environmental	Other
Reaction				

Medical History

Concerns Expressed by Minor or Caregiver:

Review of Systems (ROS) and Physical Exam

Were any signs/symptoms reported by the minor or observed by program staff or HCP? No Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy):

Sign/Symptom	• Pain, location: _____	• Fever (>37.8 C°) or chills	• Red Eyes	• Runny Nose	• Sore Throat	• Cough	• Difficulty breathing/ Shortness of Breath
Onset Date							
Sign/Symptom	• Nausea	• Vomiting	• Diarrhea	• Neck stiffness	• Headache	• Dizziness	• Confusion/Altered mental status
Onset Date							
Sign/Symptom	• Neurologic symptoms	• Skin lesions/Rash	• Yellow skin/eyes	• Swollen glands	• Unusual bleeding	• Other: _____	• Other: _____
Onset Date							

Physical exam performed by HCP: No Yes, enter the findings for each evaluated system

System	Evaluated, Findings	Describe findings
General appearance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
HEENT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neck	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Heart	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
GU/GYN	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Back/Spine	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neurologic	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Skin (include tattoos)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Other _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Laboratory Testing			
Condition	Indicators	Test	Result
Influenza	Fever + cough or sore throat	• Rapid flu	• Negative • Positive, type: • A • B • A/B • Unk
Strep throat	Sore throat + fever without cough	• Rapid strep	• Negative • Positive
Lead	Previously elevated lead level	• Capillary, Lead	• Ordered/Pending • Negative • Positive (≥5 mcg/dl), level: ____
		• Blood/Serum, Lead	• Ordered/Pending
Pregnancy	Sexual activity	• Urine pregnancy	• Negative • Positive • Indeterminate
		• Blood/Serum hCG	• Ordered/Pending
HIV	Sexual activity	• Rapid oral	• Negative • Positive • Indeterminate
		• Blood/Serum, 4 th Gen	• Ordered/Pending
Chlamydia	Sexual activity	• NAAT/PCR	• Ordered/Pending
Gonorrhea	Sexual activity	• NAAT/PCR	• Ordered/Pending
Syphilis	Sexual activity	• RPR/VRDL	• Ordered/Pending
Hepatitis B	Sexual activity or Injection drug use	• Surface antigen	• Ordered/Pending
Hepatitis C	Injection drug use	• Antibody, Total	• Ordered/Pending
Active Tuberculosis	Active TB Work Up	€ AFB smear	• Ordered/Pending
		€ TB culture	• Ordered/Pending
		€ NAAT/PCR	• Ordered/Pending
		€ MDDR	• Ordered/Pending
		€ DST	• Ordered/Pending
Other Reportable Infectious Disease:		Specify:	• Ordered/Pending

Diagnosis and Plan

Diagnosis: Minor with new complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed:
 € No, specify reason for exam (e.g., follow-up immunizations): _____
 € Yes, check all diagnoses that apply below. Specify in the space provided, where indicated.

General/Constitutional	• Anemia	• Allergy (e.g., drug reaction, food allergy): _____
• Dehydration	• Lymphadenopathy	• Malnourished
• Lead poisoning		• Pallor
• Other: _____		
HEENT	• Conjunctivitis	• Eyelid lesions
• Hearing issues: _____	• Speech impediment	• Otitis media/externa
• Vision issues: _____	• Other: _____	• Rhinitis
		• Pharyngitis (Not strep throat)
Respiratory/Pulmonary	• Asthma	• Chronic cough
• Lower respiratory illness: _____	• Upper respiratory illness: _____	• Abnormal CXR (Non-TB): _____
• Influenza, lab-confirmed: _____	• Other: _____	• Influenza-like illness (ILI)
Cardiovascular	• Arrhythmia	• Elevated blood pressure
• Heart murmur	• Congenital heart disease: _____	• Chest pain
• Syncope/fainting	• Other: _____	
• Acquired heart disease: _____		
Endocrine Disorder	• Diabetes, Type 1 and 2	• Hyper/Hypothyroidism
• Other: _____		• Delayed/Precocious puberty
Gastrointestinal	• Abdominal pain	• Constipation
• Failure to thrive	• Gastroenteritis	• Celiac disease
• Gastritis/Peptic ulcer	• Inflammatory bowel disease	• Diarrhea, Acute/Chronic
• Liver disease		• GI bleeding
• Weight loss		• Heartburn/Reflux
• Other: _____		• Jaundice
		• Intestinal parasites: _____
Genito-urinary/Reproductive	• Bed-wetting	• Hematuria
• Kidney stones	• Testicular torsion	• Proteinuria
• Urinary tract infection	• Gynecomastia/Breast Mass (fibroadenomas, cysts)	• Inguinal hernia
• Amenorrhea/Dysmenorrhea /Menorrhagia	• Pregnant: Current gestational age ____ wks, Est. due date __/__/____	• Abnormal Vaginal Bleeding/Discharge
• Pelvic Inflammatory Disease	• Spontaneous abortion	• Genital warts
• Childbirth		• Elective abortion
• Consensual sexual activity, who/when/where: _____	• Other: _____	
Neurological	• Brain tumor	• Cerebral palsy
• Cognitive disorder / IQ deficit	• Developmental delay	• Headache/Migraine
• Traumatic brain injury / Concussion	• Seizure/Epilepsy	• Cerebrovascular disease
		• Neurocysticercosis
Musculoskeletal	• Back pain	• Extremity/Joint pain
• Fracture	• Scoliosis/Kyphosis	• Bone tumors (benign/malignant)
• Sprain/Strain		• Ligamentous/Tendon injury
• Other: _____		
Skin, Hair, and Nails	• Acne	• Atopic dermatitis/Eczema
• Lice	• Ingrown toenail	• Allergic/Irritant Contact ~
• Cellulitis	• Tattoos	• Acanthosis Nigricans
• Scars	• Other: _____	• Tinea pedis
		• Hair loss/Allopecia Areat
		• Onychomycosis
Potentially Reportable Infectious Disease	• Acute hepatitis A	• Acute/chronic hepatitis B
• Chikungunya	• COVID-19	• Dengue
• HIV	• Measles	• Mumps
• Chlamydia		• Acute/chronic hepatitis C
• Malaria		• Gonorrhea
		• Pertussis

- Rubella
- Typhoid fever
- Other: _____
- Sepsis/Meningitis
- Varicella
- Syphilis
- Zika virus
- TB, active disease
- Viral hemorrhagic fever: _____
- TB, latent (LTBI)

Medical, Other

- Behavioral and Mental Health Concerns**
- Bipolar disorder
 - Eating disorder
 - PTSD
 - Nonconsensual sexual activity, who/when/where: _____
 - Conduct disorder
 - Hallucinations
 - Schizophrenia
 - ADHD/ADD
 - Depressive disorder
 - Panic disorder
 - Self-injury/cutting
 - Adjustment disorder
 - Borderline personality disorder
 - Obsessive-Compulsive Disorder
 - Separation anxiety disorder
 - Other: _____
 - Autism
 - Generalized Anxiety disorder
 - Oppositional Defiant Disorder
 - Suicide ideation/attempt

- Dental**
- Infection/abscess
 - Tooth decay/caries
 - Broken tooth or teeth
 - Tooth sensitivity
 - Gingivitis/gum disease
 - Other: _____
 - Impacted tooth/teeth

Plan: Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

Return to clinic:
 € PRN/As needed € Follow-up (specify condition, timing): _____

Minor fit to travel: € No € Yes: _____

Per program staff, discharge from ORR custody will be delayed: € No € Yes: _____

Minor has/may have an ADA disability: € No Yes: _____

€ Referred to specialist: _____

€ Minor requires quarantine/isolation, specify diagnosis and timeframe: _____

€ Medications (specify name, reason, date started, dose, and directions and indicate if psychotropic):

€ Immunizations given
 € List immunizations that were indicated, but not given and state why: _____

€ Age-appropriate anticipatory guidance discussed and/or handout given

€ Surgery/procedure needed/performed: _____

€ Physical/dietary restrictions: _____

€ Visiting nurse services required: _____

€ Physical/Occupational/Speech therapy required: _____

€ Durable medical equipment required: _____

€ Per local/state reporting guidelines, Health Department was notified of suspect/confirmed diagnosis of a reportable infectious disease
 Were other minors in ORR custody potentially exposed during infectious period? € No € Yes
 Grantee staff members at shelter potentially exposed, how many? _____

€ Other: _____

Recommendations from Healthcare Provider / Additional Information

Healthcare Provider Signature: _____ **Date:** ____/____/____

Healthcare Provider Printed Name: _____

The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. Public reporting burden for this collection of information is estimated to average 9 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279: Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996]). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0509 and the expiration date is XX/XX/XXXX. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.

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