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| **Initial Medical Exam 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**  | Phone number: | Clinic or Practice: |
| Street address: | City or Town: | State: | Date evaluated:  |
| **Program**  | Program name: | * 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
 |
|  | **Food** | **Medication** | **Environmental** | **Other** |
| Allergen |  |  |  |  |
| Reaction |  |  |  |  |
| **Vision Screening** (> 3 years): | * No
 | * Yes, specify below
 | **Hearing Screening:** | * No
 | * Yes, specify below
 |
|  | **Right Eye** | **Left Eye** | **Both eyes** | **Final**  | OAE/ABR | * Pass
 | * Fail
 |
| Corrected | 20 / | 20 / | 20 / | * Pass
 | * Fail
 | Gross Hearing (< 4 Years) | * Pass
 | * Fail
 |
| Uncorrected | 20 / | 20 / | 20 / | * Pass
 | * Fail
 | Pure Tone Audiometry (>= 4 Years) Result | * Pass
 | * Fail
 |
| **Medical History** |
| Concerns expressed by child or caregiver: | * No
 | * Yes, specify:
 |
|  |
| Past medical history (include surgeries and hospital admissions):  |
| Was healthcare received in DHS custody?  | * No
 | * Yes, specify:
 |
|  |
| Social/Family History: |
| Travel history (countries visited, dates of arrival and departure for each): |
| Reproductive History:  | * Menarche: Date of LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, if unknown, months since LMP: \_\_\_\_\_\_;
 | * Pregnancy: Gravida \_\_\_\_\_\_ Parity \_\_\_\_\_\_
 |
| * N/A
 |
| **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 Co) 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** |  |  |  |  |  |  |  |

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| **Physical Examination** |
| **System** | **Not eval** | **Evaluated, Findings** | **Describe or if not evaluated, provide reason** |
| General appearance |  | * Normal
 | * Abnormal
 |  |
| HEENT |  | * Normal
 | * Abnormal
 |  |
| Neck |  | * Normal
 | * Abnormal
 |  |
| Heart |  | * Normal
 | * Abnormal
 |  |
| Lungs |  | * Normal
 | * Abnormal
 |  |
| GU/GYN |  | * Normal
 | * Abnormal
 |  |
| Extremities |  | * Normal
 | * Abnormal
 |  |
| Abdomen |  | * Normal
 | * Abnormal
 |  |
| Back/Spine |  | * Normal
 | * Abnormal
 |  |
| Neurologic |  | * Normal
 | * Abnormal
 |  |
| Skin (include tattoos)  |  | * Normal
 | * Abnormal
 |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Normal
 | * Abnormal
 |  |
| **Psychosocial Risk**  |
| **Mental Health Concerns** (< 3 mos) | * Yes, specify below
 | * Denied, with no obvious signs/symptoms
 | * Denied, but obvious signs/symptoms present
 | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Is minor able to attribute these feelings to a specific reason(s)? | * No
 | * Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Physical Abuse History** | * Yes, specify below
 | * Denied, with no obvious signs/symptoms
 | * Denied, but obvious signs/symptoms present
 | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Part/All of abuse related to gang violence
 | * In home country
 | * During journey to U.S.
 |
| * In U.S., not in ORR custody
 | * In ORR custody
 |
| **Sexual Activity History** | * Yes, specify below
 | * Denied, with no obvious signs/symptoms
 | * Denied, but obvious signs/symptoms present
 | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Sexual activity (Oral/Vaginal/Anal)** | **Date of Last Encounter**  | **Location** |
| **In home country** | **During journey to U.S.** | **In U.S., not in ORR custody** | **In ORR custody** |
| * Consensual
 | \_\_\_/\_\_\_/\_\_\_\_ |  |  |  |  |
| Specify: |
| * Nonconsensual
 | \_\_\_/\_\_\_/\_\_\_\_ |  |  |  |  |
| Specify: |
| **Substance Use History**  | * Yes, specify below
 | * Denied, with no obvious signs/symptoms
 | * Denied, but obvious signs/symptoms present
 | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  | **Alcohol** | **Tobacco / Nicotine** | **Marijuana** | **Injection drugs** | **Other substances** |
| Specify substance(s) |  |  | N/A |  |  |
| Frequency of use |  |  |  |  |  |
| Date of last use |  |  |  |  |  |
| **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 | 6 mos up to 6 yrs | * Capillary, Lead
 | * Ordered/Pending
 | * Negative
 | * Positive (>5 mcg/dl), level: \_\_\_
 |
| * Blood/Serum, Lead
 | * Ordered/Pending
 |
| Pregnancy | ­>10 yrs or < 10 yrs who have reached menarche or sexual activity | * Urine pregnancy
 | * Negative
 | * Positive
 | * Indeterminate
 |
| * Blood/Serum hCG
 | * Ordered/Pending
 |
| HIV | >13 yrs or Sexual activity  | * Rapid oral
 | * Negative
 | * Positive
 | * Indeterminate
 |
| * Blood/Serum, 4th 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 | * Total antibody
 | * Ordered/Pending
 |
| Other Reportable Infectious Disease (Non-TB):  | Specify: | * Ordered/Pending
 |

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| **TB Lab Testing** (Use Supplemental TB Screening form for result documentation) |
| Has minor ever been a close contact to a person with ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has minor ever been treated for ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has minor ever been treated for ***latent*** TB infection? | * No
 | * Yes, specify:
 |
| **TB screening method ordered:** | * TST (<2 yrs)
 | * IGRA (>2 yrs)
 | * CXR (>15 yrs)
 | * Was or will be tested elsewhere
 |
| **Diagnosis and Plan** |
| **Diagnosis:** | Minor with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: | * No
 | * Yes
 |
| If **Yes**, check all diagnoses that apply. Specify in the space provided, where indicated. |
| **General/Constitutional** | * Anemia
 | * Allergy (e.g., drug reaction, food allergy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Dehydration
 | * Lead poisoning
 | * Lymphadenopathy
 | * Malnourished
 | * Pallor
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **HEENT** | * Conjunctivitis
 | * Eyelid lesions
 | * Otitis media/externa
 | * Rhinitis
 |
| * Hearing issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Speech impediment
 | * Strep throat
 | * Pharyngitis (Not strep throat)
 |
| * Vision issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Respiratory/Pulmonary** | * Asthma
 | * Chronic cough
 | * Abnormal CXR (Non-TB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Lower respiratory illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Upper respiratory illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Influenza-like illness (ILI)
 |
| * Influenza, lab-confirmed
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Cardiovascular** | * Arrhythmia
 | * Elevated blood pressure
 | * Chest pain
 |
| * Heart murmur
 | * Syncope/fainting
 | * Congenital heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Acquired heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Endocrine Disorder** | * Diabetes, Type 1 and 2
 | * Hyper/Hypothyroidism
 | * Delayed/Precocious puberty
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Gastrointestinal** | * Abdominal pain
 | * Constipation
 | * Celiac disease
 | * Diarrhea, Acute/Chronic
 |
| * Failure to thrive
 | * Gastritis/Peptic ulcer
 | * Gastroenteritis
 | * GI bleeding
 | * Heartburn/Reflux
 | * Jaundice
 |
| * Liver disease
 | * Weight loss
 | * Inflammatory bowel disease
 | * Intestinal parasites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Genito-urinary/Reproductive** | * Bed-wetting
 | * Hematuria
 | * Proteinuria
 | * Inguinal hernia
 |
| * Kidney stones
 | * Urinary tract infection
 | * Testicular torsion
 | * Hydrocele/Varicocele
 | * Abnormal Vaginal Bleeding/Discharge
 |
| * Amenorrhea/Dysmenorrhea /Menorrhagia
 | * Gynecomastia/Breast Mass (fibroadenomas, cysts)
 | * Consensual sexual activity
 |
| * Pelvic Inflammatory Disease
 | * Genital warts
 | * Pregnant
 | * Childbirth
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Neurological** | * Brain tumor
 | * Cerebral palsy
 | * Cerebrovascular disease
 |
| * Cognitive disorder/IQ deficit
 | * Developmental delay
 | * Headache/Migraine
 | * Neurocysticercosis
 |
| * Traumatic brain injury / Concussion
 | * Seizure/Epilepsy
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Musculoskeletal** | * Back pain
 | * Extremity/Joint pain
 | * Bone tumors (benign/malignant)
 |
| * Fracture
 | * Sprain/Strain
 | * Scoliosis/Kyphosis
 | * Ligamentous/Tendon injury
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Skin, Hair, and Nails** | * Acne
 | * Atopic dermatitis/Eczema
 | * Allergic/Irritant Contact Dermatitis
 |
| * Lice
 | * Scabies
 | * Ingrown toenail
 | * Acanthosis Nigricans
 | * Hair loss/Alopecia Areata
 |
| * Cellulitis
 | * Ringworm
 | * Tattoos
 | * Tinea pedis
 | * Onychomycosis
 |
| * Scars
 | * Warts
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Potentially Reportable Infectious Disease** | * Acute hepatitis A
 | * Acute/chronic hepatitis B
 | * Acute/chronic hepatitis C
 |
| * Chikungunya
 | * Chlamydia
 | * COVID-19
 | * Dengue
 | * Gonorrhea
 |
| * HIV
 | * Malaria
 | * Measles
 | * Mumps
 | * Pertussis
 |
| * Rubella
 | * Sepsis/Meningitis
 | * Syphilis
 | * TB, active disease
 | * TB, latent (LTBI)
 |
| * Typhoid fever
 | * Varicella
 | * Zika virus
 | * Viral hemorrhagic fever: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Medical, Other** |  |
| **Behavioral and Mental Health Concerns** | * Anxiety symptoms (e.g., panic attacks, excessive worry/fear)
 | * Depressive symptoms
 |
| * Manic symptoms (e.g., elated mood, pressured speech)
 | * Trauma symptoms (e.g., nightmares, flashbacks)
 | * Hallucinations
 |
| * Delusions
 | * Behavioral concerns (e.g., aggression, trouble following rules)
 | * Social/Emotional delay
 |
| * History of psychiatric diagnoses or treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Urge for/current self-harm
 | * Urge for/current harm to others
 |
| * Nonconsensual sexual activity
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Dental** | * Broken tooth or teeth
 | * Gingivitis/gum disease
 | * Impacted tooth/teeth
 |
| * Infection/abscess
 | * Tooth decay/caries
 | * Tooth sensitivity
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

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| **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 diagnosis, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Minor fit to travel | * Yes
 | * No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  Per program staff, discharge from ORR custody will be delayed: | * No
 | * Yes (specify diagnosis, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Minor has/may have an ADA disability: | * No
 | * Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Referred to specialist/counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Minor requires quarantine/isolation, specify diagnosis and timeframe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Medications (specify name, diagnosis treated, date started, dose, and directions and indicate if psychotropic):
 |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Immunizations given/validated from foreign record
* List immunizations that were indicated, but not given and state why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Age-appropriate anticipatory guidance discussed and/or handout given
 |
| * 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
 |
|  Were grantee staff members potentially exposed at care provider program? | * No
 | * Yes
 |
| * Other:
 |
| **Recommendations from Healthcare Provider / Additional Information** |
|  |
| **Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_****Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. **P**ublic reporting burden for this collection of information is estimated to average 13 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 0970-0466 and the expiration date is 12/31/2023. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.

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