OMB Control No: 0970-0509
Expiration date: 12/31/2023

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:	• 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				

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	€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	

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, 4th Gen	• Ordered/Pending
Chlamydia	Sexual activity	• NAAT/PCR	• Ordered/Pending
Gonorrhea	Sexual activity	• NAAT/PCR	• Ordered/Pending
Syphilis	Sexual activity	• RPR/VDRL	• 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 € TB culture € NAAT/PCR € MDDR € DST	• Ordered/Pending • Ordered/Pending • Ordered/Pending • Ordered/Pending • Ordered/Pending
Other Reportable Infectious Disease(s), specify:		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	• 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)		• Genital warts
• Pelvic inflammatory disease	• Pregnant: Current gestational age _____ wks, Est. due date __/__/____		• Childbirth
• Spontaneous abortion • Elective abortion	• Consensual sexual activity, who/when/where: _____		
• 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/treatment: _____
- Urge for/current self-harm
- Urge for/current harm to others
- Nonconsensual sexual activity, who/when/where: _____
- Other: _____

DSM diagnosis if criterion met (select from following options):

- ADHD
- Adjustment disorder
- Autism
- Bipolar disorder
- Conduct disorder
- Major depressive disorder
- Eating disorder
- Generalized anxiety disorder
- Oppositional defiant disorder
- Panic disorder
- Acute stress disorder/PTSD
- Primary psychotic disorder
- Other: _____

Dental

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

Plan: Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization reco 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: _____
€ 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
Were grantee staff members potentially exposed at shelter? • No • Yes
€ 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 12/31/2023. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.