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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Assessment Form**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child** | | | | Last name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | First name: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOB: | | | | | | | | | | | A#: | | | | | | | | | | | | | | Gender: | | | | | | | | | Date evaluated: | | | | | | | | | | | | | Time evaluated: | | | | | | | | |
| Primary language:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | Who provided appropriate language services for child during evaluation? | | | | | | | | | | | | | | | | | | * HCP fluent in child’s primary language | | | | | | | | | * Trained interpreter | | | | | | | | | | | | * Not provided | |
| **Evaluating Healthcare Provider (HCP)** | | | | Name:  **MD / DO / PA / NP** | | | | | | | | | | | | | | | | | | | | | | | | | | Phone number: | | | | | | | | | | | | | | Clinic or Practice: | | | | | | | | | | | | | | | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | City/Town: | | | | | | | | | | | | | | | | | | | | State: | | | | | | |
| Location where child received care (e.g., Primary health care provider/Pediatrician, medical specialist): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Program** | | | | Program name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * Program Staff Member Present During Exam with HCP | | | | | | | | | | | | | | | | | | | |
| **Reason for visit:** | | | | * Initial medical exam (IME)\* | | | | | | | | | | | | | | | | | | | | * New complaint/concern | | | | | | | | | | | | | | | * Follow-up visit with PCP for previous complaint/concern | | | | | | | | | | | | | | | | | | | | |
| * Specialist visit, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | * Routine well-child check/Establish care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **History and Assessment\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Temperature (T)** | | | | | | | **Heart Rate (HR)** | | | | | | | | | | **BP (> 3 yrs)** | | | | | | | | | **Resp Rate (RR)** | | | | | | | | **Height (HT)** | | | | | | | **Weight (WT)** | | | | | | **BMI (>2 yrs)** | | | | | | | | | | **BMI %ile** | | |
| 0C | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | cm | | | | | | | kg | | | | | |  | | | | | | | | | |  | | |
| **Allergies:** | | * No | | | | | | | * Yes, specify below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Food** | | | | | | | | | | | | | | | | | | | | | | **Medication** | | | | | | | | | | | | | | | | | | | | **Environmental** | | | | | | | | | | | | | | |
| Allergen | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Reaction | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Vision Screening** (> 3 years): | | | | | | | | | | | | * Yes, specify below | | | | | | | | | | * Not performed | | | | | | | | | | **Hearing Screening:** | | | | | | | | | | * Yes, specify below | | | | | | | | * Not performed | | | | | | | | | |
|  | | | | | **Right Eye** | | | | | | | **Left Eye** | | | | | **Both eyes** | | | | | | **Final** | | | | | | | | | OAE/ABR (Preferred for < 4 years) | | | | | | | | | | | | | | | | | | | | | | | | * Pass | | | * Fail |
| Corrected | | | | | 20 / | | | | | | | 20 / | | | | | 20 / | | | | | | * Pass | | | | | * Fail | | | | Pure Tone Audiometry (Preferred for ≥ 4 years) | | | | | | | | | | | | | | | | | | | | | | | | * Pass | | | * Fail |
| Uncorrected | | | | | 20 / | | | | | | | 20 / | | | | | 20 / | | | | | | * Pass | | | | | * Fail | | | | Gross Hearing (Acceptable for all ages) | | | | | | | | | | | | | | | | | | | | | | | | * Pass | | | * Fail |
| **Medical & Mental Health History (including dates & locations of care)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic/Underlying conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Healthcare received in DHS custody/during journey: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications (dosage frequency & dates):** | | | | | | | | | * Past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Current: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reproductive History (complete for anatomically female UC who have started menarche):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, if unknown, months since LMP: \_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * Current contraceptive use | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnancy: Gravida \_\_\_\_\_\_ Parity \_\_\_\_\_\_; location & age of child(ren): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * Currently breastfeeding | | | | | | | | | | |
| **History of abuse:** | | | | | | | | * Yes, specify | | | | | | * Denied, with no obvious signs | | | | | | | | | | | | | | | | | | | | | * Denied, but obvious signs present | | | | | | | | | | | | | * Unknown | | | | | | | | | | | |
| Type(s): | * Verbal | | | | | | | | | | * Emotional | | | | | | | * Physical, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Sexual (with or without penetration), estimated date of last encounter: \_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Other victimization (e.g., gang, bullying, crime): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consensual sexual activity (with penetration):** | | | | | | | | | | | | | | | | | | | * No | | | | | | | | * Yes, estimated date of last encounter: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | * Unknown | | | | | |
| **Substance use:** | | | | | | * Yes, specify | | | | | | | * Denied, with no obvious signs/symptoms | | | | | | | | | | | | | | | | | | | | | | | * Denied, but obvious signs/symptoms present | | | | | | | | | | | | | | | | | | | * Unknown | | | | |
|  | | | | | | | | | | **Alcohol** | | | | | | | | | | **Tobacco/Nicotine** | | | | | | | | | | | **Marijuana** | | | | | | | | | | | | **Injection drugs (IDU)** | | | | | | | | | **Other substances** | | | | | | | |
| Specify substance(s) | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | N/A | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
| Frequency/Quantity | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
| Date of last use | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
| **Travel history:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Review of Systems (ROS) and Physical Exam\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Concerns expressed by child/caregiver:** | | | | | | | | | | | | | | | | No | | | | | * Yes, specify:   Page 1 of 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Were any physical signs/symptoms reported by the child 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** | |  | | |  | |  | | | | |  | | | |  | | |  | | | |  | | | |
| **Physical Examination\*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Systems** | | | **Normal findings** | | | | | | | | | | | **Abnormal findings, specify or if not evaluated, give reason:** | | | | | | | | | | | | |
| General | | | * Well-appearing/nourished; no distress; developmentally appropriate | | | | | | | | | | |  | | | | | | | | | | | | |
| Head/Neck | | | * Normocephalic, neck supple; no adenopathy or masses | | | | | | | | | | |  | | | | | | | | | | | | |
| Eyes | | | * PERRL, EOMI; no redness/discharge | | | | | | | | | | |  | | | | | | | | | | | | |
| ENT/Dental | | | * TMs WNL; no rhinorrhea; o/p w/o erythema, lesions, caries, abscess | | | | | | | | | | |  | | | | | | | | | | | | |
| Cardiovascular | | | * Regular rate & rhythm; no murmurs; normal pulses; cap refill < 3 sec | | | | | | | | | | |  | | | | | | | | | | | | |
| Lungs | | | * Clear to auscultation, no wheezes, crackles, rhonchi, no accessory muscle use | | | | | | | | | | |  | | | | | | | | | | | | |
| Abdomen | | | * Non-distended; soft and non-tender; no masses or organomegaly | | | | | | | | | | |  | | | | | | | | | | | | |
| Genitourinary | | | * External GU normal; Tanner \_\_\_\_\_: no lesions, discharge, hernia | | | | | | | | | | |  | | | | | | | | | | | | |
| Musculoskeletal/Back/Extremities | | | * Full range of motion of all extremities; no joint swelling, erythema; no scoliosis | | | | | | | | | | |  | | | | | | | | | | | | |
| Neurologic | | | * Typical gait, strength, tone, sensation, speech & behavior for age | | | | | | | | | | |  | | | | | | | | | | | | |
| Skin | | | * No rashes, lesions, jaundice, pallor, scars, birthmarks, or tattoos | | | | | | | | | | |  | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?** | | | | | | | | | | | | | | | | | | * No | | * Yes, specify below: | | | | | | |
| * Feels empty, hopeless, sad, numb more often than not | | | | | | | | | | | | * Has trouble eating, sleeping | | | | | | | | | | | | | | |
| * Feels constantly worried, anxious, nervous more often than not | | | | | | | | | | | | * Has nightmares | | | | | | | | | | | | | | |
| * Experiences mood swings, from very high to very low | | | | | | | | | | | | * Engages in self-harm | | | | | | | | | | | | | | |
| * Relives traumatic events from the past | | | | | | | | | | | | * Hears voices or sees things others do not see (hallucinations) | | | | | | | | | | | | | | |
| * Feels easily annoyed or irritated | | | | | | | | | | | | * Thoughts of hurting others | | | | | | | | | | | | | | |
| * Feels afraid, easily startled, jumpy | | | | | | | | | | | | * Thoughts of hurting self, would be better dead | | | | | | | | | | | | | | |
| * Has trouble concentrating, restless, too many thoughts | | | | | | | | | | | | * Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Is child able to attribute these feelings to a specific reason(s)? | | | | | | | | * No | | | * Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Laboratory Testing\*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Condition** | **Indicators** | | | | | | | | | **Test** | | | | | | | **Result** | | | | | | | | | |
| CBC w/ diff | <6 yrs at IME | | | | | | | | | * Blood/Serum | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Lead | <6 yrs, lactating or pregnancy at IME | | | | | | | | | * Capillary, Lead | | | | | | | * Negative | | | * Positive (>3.5 μg/dL), level: \_\_\_\_\_ | | | | | | |
| * Blood/Serum, Lead | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Pregnancy | ­>10 yrs or <10 yrs who have reached menarche at IME, sexual activity/abuse/assault | | | | | | | | | * Urine pregnancy | | | | | | | * Negative | | | * Positive | * Indeterminate | | | | | |
| HIV | All children at IME | | | | | | | | | * Rapid, fingerstick/oral | | | | | | | * Negative | | | * Positive | * Indeterminate | | | | | |
| * Blood/Serum, 4th Gen | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Syphilis | <2 yrs & not with biological mother at IME, sexual activity/abuse/assault | | | | | | | | | * RPR/VDRL | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Chlamydia | Sexual activity/abuse/assault | | | | | | | | | * NAAT/PCR | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Gonorrhea | Sexual activity/abuse/assault | | | | | | | | | * NAAT/PCR | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Hepatitis B | Pregnancy, sexual abuse/assault, IDU, country-based | | | | | | | | | * Surface antigen | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Hepatitis C | Pregnancy, IDU | | | | | | | | | * Total antibody | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| COVID-19 | Any COVID-19 symptom, incl. but not ltd. to runny nose, sore throat, cough, headache, diarrhea | | | | | | | | | Rapid: | | | * Ag | | * PCR | | * Negative | | | * Positive | | * Indeterminate | | | | |
| * NAAT/PCR | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Influenza | Fever + cough or sore throat | | | | | | | | | * Rapid flu | | | | | | | * Negative | | | * Positive, type(s): | | | | * A | * B | * Unk |
| Strep throat | Sore throat + fever without cough, HCP discretion | | | | | | | | | * Rapid strep | | | | | | | * Negative, | | | * culture ordered | | | | * Positive | | |
| Other Reportable Infectious Disease (Non-TB): | | | | Specify: | | | | | | | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |
| Specify: | | | | | | | | | | | | | * Ordered | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | |

Page 2 of 4

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TB Screening\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has child ever been exposed to a person with ***active*** TB disease? | | | | | | | | | | | | | | | * No | | | * Yes, specify: | | | | | | | | | | | | | | | | |
| Has child ever been treated for TB? | | | | | | * No | | | | * Yes, specify type & details: | | | | | | | | | * Active TB disease | | | | | | | | | * Latent TB infection (LTBI) | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TB screening indicator** | | | | | **Test** | | | | | | | | | | | | | | | **Result** | | | | | | | | | | | | | | |
| <2 yrs of age at IME | | | | | * PPD/Tuberculin skin test (TST) | | | | | | | | | | | | | | | * Ordered | | | | | | | * Pending; date performed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_,   date read: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_; Result (mm): \_\_\_\_\_ | | | | | | | |
| >2 yrs of age at IME | | | | | TB blood test (IGRA):   * QuantiFERON®-TB Gold In-Tube test (QFT-GIT) | | | | | | | | | | | | | | | * Ordered | | | | | | | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | | |
| * T-SPOT®.TB test (T-Spot) | | | | | | | | | | | | | | |
| >15 yrs of age at IME | | | | | * Single view (PA) CXR | | | | | | | | | | | | | | | * Ordered | | | | | | | * Pending; performed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | | |
| <15 yrs and + TST/IGRA or exposure/treatment history | | | | | * 2-view (PA and lateral) CXR | | | | | | | | | | | | | | | * Ordered | | | | | | | * Pending; performed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | | | | | | | |
| **TB Screening Outcome:** | * Pending | | | | * Negative for TB condition; No further follow up needed | | | | | | | | | | | * TB, Latent (LTBI) | | | | | * Referred to Health Department/ specialist for active TB evaluation | | | | | | | | | | | * Not performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **If referred to HD/specialist, was an active TB work-up initiated?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * No, specify reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Yes, specify reason: | | | * Signs/Symptoms | | | | | | | | * Abnormal imaging | | | | | | * Exposure history | | | | | | | | | * Initiation of LTBI treatment | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_ | |
| * Specimen collected by HD/specialist: | | | | | | | | | Specimen type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | Tests ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Diagnosis and Plan\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis:** Child 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** | | | | **HEENT** | | | | | | | | **Respiratory/Pulmonary** | | | | | | | | | | | | | **Cardiovascular** | | | | | | **Gastrointestinal** | | | |
| * Allergic reaction * Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Anemia * Dehydration * Developmental delay * Lead in blood * Fatigue * Lymphadenopathy * Obesity * Sickle cell disease * Underweight/Weight loss * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | * Allergic rhinitis * Cerumen impaction * Conjunctivitis * Hearing issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Otitis externa * Otitis media * Pharyngitis, strep * Pharyngitis, other * Vision issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Abnormal CXR (Non-TB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Asthma, severity: \_\_\_\_\_\_\_\_\_ * Bronchiolitis * Chronic cough * Croup * Influenza, lab-confirmed * Influenza-like illness (ILI) * Pneumonia * Shortness of breath/wheezing * Upper respiratory illness * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | * Arrhythmia * Chest pain * Congenital heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * High blood pressure * Heart murmur * Myocarditis/Pericarditis/ Endocarditis * Syncope/Fainting * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | * Abdominal pain * Appendicitis * Constipation * Diarrhea, acute/chronic * Failure to thrive * Gastritis/Peptic ulcer * Gastroenteritis * GI bleeding * Heartburn/Reflux * Inflammatory bowel disease * Intestinal parasites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Jaundice * Liver disease * Nausea/Vomiting * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Dental** | | | | | | | | | | | | **Endocrine Disorder** | | | | | | | | | | | | | | | | | | |
| * Broken tooth/teeth * Gingivitis/Gum disease * Impacted tooth/teeth * Infection/abscess | | | | * Missing tooth/teeth * Tooth decay/caries * Tooth sensitivity * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Acanthosis nigricans * Delayed/Precocious puberty * Diabetes, Type 1 and 2 | | | | | | | | | | | | * Hyper/Hypothyroidism * Short stature * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Genito-urinary/Reproductive** | | | | | | | | | | | | | | **Musculoskeletal** | | | | | | | | | | **Potentially Reportable Infectious Disease** | | | | | | | | | | |
| * Abnormal vaginal bleeding/Discharge * Amenorrhea/Menorrhagia /Dysmenorrhea * Bed-wetting * Childbirth * Consensual sexual activity * Elective abortion * Genital lesions * Gynecomastia/Benign breast mass * Herpes simplex virus * Inguinal hernia | | | | * Kidney disease/stones * Menstrual cramping/pain * Pelvic inflammatory disease * Pregnant, gestational age: \_\_\_\_\_ wks; est. due date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_ * Proteinuria/Hematuria * Sexual abuse/assault * Spontaneous abortion * Testicular pain/Torsion * Urinary tract infection * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | * Back pain * Bone tumors (benign/malignant) * Extremity/Joint pain * Fracture * Hematoma/Bruise * Ligamentous/Tendon injury * Myalgia * Scoliosis/Kyphosis * Sprain/Strain * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Neurological** | | | | | | | | | | | | | | **Skin, Hair, and Nails** | | | | | | | | | | | | | | | | | | | | |
| * Brain tumor * Cerebral palsy * Cerebrovascular disease * Headache/Migraine * Seizure/Epilepsy | | | | * Traumatic brain injury/ Concussion * Vertigo/Dizziness * Weakness * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | * Acne * Atopic dermatitis/Eczema * Cellulitis/Abscess * Contact dermatitis * Diaper rash * Hair loss/Alopecia areata | | | | | | | | | | * Impetigo * Ingrown toenail * Lice * Onychomycosis * Scabies * Scars | | | | | | | * Tattoos * Tinea pedis/corporis/ cruris/capitis * Urticaria * Warts * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Page 3 of 4 | | | |
| **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 | | | | | | | * Urge for/current self-harm | | | | | |
| * Urge for/current harm to others | | | | | | | | * History of psychiatric diagnoses or treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * 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. | |
| * Immunizations administered during visit | |
| * Immunizations documented on foreign record reviewed and validated | |
| * Immunizations indicated but not given; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Age-appropriate anticipatory guidance discussed and/or handout given | |
| * Child educated on healthcare services received and treatment recommendations | |
| * Medications administered/prescribed:  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Medication Name | Reason | Date Started | Expected end date | Dose | Directions | Psychotropic? | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | | |
| * Child requires isolation for a communicable disease; specify diagnosis, start/end dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency: | |
| * Onsite care provider clinician evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Increased level of supervision for mental health concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Assistance with daily living activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Durable medical equipment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Physical activity restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Dietary restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Child has/may have an ADA disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Child has health concerns that require follow-up services; specify needs and time frame by when services should occur: | |
| * Return to clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Mental health specialist evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Medical specialist evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Physical/Occupational/Speech therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Surgery/Procedure needed/performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Child cleared to travel:** | * Yes, with no restrictions |
| * Yes, with restrictions (e.g., ground travel, travel safety plan, travel length): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * No, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Recommendations from Healthcare Provider / Additional Information** | |
|  | |
| **Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_**  **Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

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Page 4 of 4