|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Public Health Investigation Form: Non-TB Illness**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child** | Last name: | | | | | | First name: | | | | | | | | | | | | | | | | | |
| DOB: | | | | | | | | | A#: | | | | | | | | | | | Gender: | | | |
| **Program** | Program name: | | | | | | | | | | | | Person completing form & date: | | | | | | | | | | | |
| **Exposure Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Illness of exposure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Source of potential exposure:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Date of first potential exposure:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ | | | | | | | | | **Date of last potential exposure:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Exposure details (e.g., child was potentially exposed for 4 hours a day in class for 5 consecutive days):** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Was child screened for illness-specific signs/symptoms upon notification of exposure?** | | | | | | | | | | | | | | | | | | * No | | * Yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | |
| **If screened, did child have illness-specific signs/symptoms?** | | | | | | | | | | | | * No | | * Yes | | | | | | | | | | |
| **If *Yes*, was child evaluated by a healthcare provider?** | | | | | | | | | | * No | | * Yes (Complete Medical Assessment Form) | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Public Health Actions** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Select *No* or *Yes* for each question below. If *Yes*, enter the information in the corresponding table.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications given:** | | | * No | | * Yes | | | | | | | | | | | | | | | | | | | |
| **Medication name** | | | | **Date started** | | **Date discontinued** | | | | | **Dose** | | | | | **Directions** | | | | | | | **Psychotropic** | |
|  | | | |  | |  | | | | |  | | | | |  | | | | | | | * No | * Yes |
|  | | | |  | |  | | | | |  | | | | |  | | | | | | | * No | * Yes |
| **Immunizations administered and/or indicated because of this exposure, but not given:** | | | | | | | | | | | | | | | | | * No | | * Yes | | | | | |
| **Vaccine name** | | | | | **Date administered OR if indicated, but not given, state reason** | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Lab testing performed:** | | | * No | | * Yes | | | | | | | | | | | | | | | | | | | |
| **Illness** | | **Test** | | | | | | **Specimen Collection Date** | | | | | | | **Specimen Source** | | | | | | | **Result** | | |
|  | |  | | | | | |  | | | | | | |  | | | | | | |  | | |
|  | |  | | | | | |  | | | | | | |  | | | | | | |  | | |
| **Was child quarantined?** | | | * No | | * Yes, quarantine start date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ , quarantine end date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Outcome of ORR public health investigation** (Check one): | | | | | | | | | | | | | | | | | | | | | | | | |
| * Pending | | | | | | | | | | | | | | | | | | | | | | | | |
| * Cleared | | | | | | | | | | | | | | | | | | | | | | | | |
| * Diagnosed with illness of exposure (Complete Medical Assessment Form) | | | | | | | | | | | | | | | | | | | | | | | | |
| * Incomplete evaluation, reason (e.g., runaway, age-out): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| **Comments:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |

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 5 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](mailto:UACPolicy@acf.hhs.gov).