OMB Control No: 0970-0466
Expiration date: 10/31/2026

# Medical Assessment Form
# Unaccompanied Alien Children Bureau
# Office of Refugee Resettlement (ORR)

## General Information

**Child**

Last name: | First name:

DOB: | A#: | Sex: | 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 |
|---|---|---|---|---|---|---|---|
| $^0$C | | | | cm | kg | | |

**Allergies:** € No € Yes, specify below:

| | Food | Medication | Environmental |
|---|---|---|---|
| Allergen | | | |
| Reaction | | | |

**Vision Screening** (≥ 3 years): • Yes, specify below • Not performed

| | Right Eye | Left Eye | Both eyes | Final |
|---|---|---|---|---|
| Corrected | 20 / | 20 / | 20 / | • Pass • Fail |
| Uncorrected | 20 / | 20 / | 20 / | • Pass • Fail |

**Hearing Screening:** € Yes, specify below € Not performed

| | | |
|---|---|---|
| OAE/ABR (Preferred for < 4 years) | • Pass | • Fail |
| Pure Tone Audiometry (Preferred for ≥ 4 years) | • 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: ____ / ____ / _____, • Approximate • Exact • Contraceptive use, specify (e.g., IUD, pills): _____
Pregnancy history: • No • Yes, # of: vaginal deliveries ____, C-sections ____, miscarriages/abortions ____, ectopics ____, living children _____
Pregnancy/Postpartum complications: _____ • 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:

| **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 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 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
- Feels constantly worried, anxious, nervous more often than not
- Experiences mood swings, from very high to very low
- Relives traumatic events from the past
- Feels easily annoyed or irritated
- Feels afraid, easily startled, jumpy
- Has trouble concentrating, restless, too many thoughts
- Has trouble eating, sleeping
- Has nightmares
- Engages in self-harm
- Hears voices or sees things others do not see (hallucinations)
- Thoughts of hurting others
- Thoughts of hurting self, would be better dead
- 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 | Specify: | | • Ordered • Pending; collected: ____/____/____ |

| Disease (Non-TB): | Specify: | • Ordered • Pending; collected: ____/____/____ |
|---|---|---|

## 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):<br>• QuantiFERON®-TB Gold In-Tube test (QFT-GIT)<br>€ T-SPOT®.TB test (T-Spot) | € Ordered € Pending; collected: ____/____/_____ |
| ≥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

- Allergic reaction
- Allergy: _____
- Anemia
- Dehydration
- Developmental delay
- Lead in blood
- Fatigue
- Lymphadenopathy
- Obesity
- Sickle cell disease
- Underweight/Weight loss
- Other: _____

### HEENT

- Allergic rhinitis
- Cerumen impaction
- Conjunctivitis
- Hearing issues: _____
- Otitis externa
- Otitis media
- Pharyngitis, strep
- Pharyngitis, other
- Vision issues: _____
- Other: _____

### Respiratory/Pulmonary

- 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: _____

### Cardiovascular

- Arrhythmia
- Chest pain
- Congenital heart disease: _____
- High blood pressure
- Heart murmur
- Myocarditis/Pericarditis/ Endocarditis
- Syncope/Fainting
- Other: _____

### Gastrointestinal

- 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

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

### Endocrine Disorder

- Acanthosis nigricans
- Delayed/Precocious puberty
- Diabetes, Type 1 and 2
- Hyper/Hypothyroidism
- Short stature
- Other: _____

### Genito-urinary/Reproductive

- Abnormal vaginal discharge
- Abortion
- Amenorrhea/Abnormal uterine bleeding
- Bed-wetting
- Childbirth
- Consensual sexual activity
- Genital lesions
- Gynecomastia/Breast mass
- Herpes simplex virus
- Inguinal hernia
- Kidney disease/stones
- Menstrual cramping/pain
- Miscarriage
- Pelvic inflammatory disease
- Pregnant, gestational age: _____ wks; est. due date: ___/____/_____
- Proteinuria/Hematuria
- Sexual abuse/assault
- Testicular pain/Torsion
- Urinary tract infection
- Other: _____

### Musculoskeletal

- Back pain
- Bone tumors (benign/malignant)
- Extremity/Joint pain
- Fracture
- Hematoma/Bruise
- Ligamentous/Tendon injury
- Myalgia
- Scoliosis/Kyphosis
- Sprain/Strain
- 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: _____

### 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: _____

**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: _____

**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:** _____