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): • QuantiFERON®-TB Gold In-Tube test (QFT-GIT) € 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: _____