|  |
| --- |
| **Public Health Investigation Form: Non-TB Illness****Unaccompanied Alien Children Bureau****Office of Refugee Resettlement (ORR)** |
| **General Information**  |
| **Child** | Last name: | First name: |
| DOB:   | A#: | Sex: |
| **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 09/30/2026. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.