

**Onsite Health Intervention (OHI) Form
Unaccompanied Alien Children Bureau
Office of Refugee Resettlement (ORR)**

Instructions: Care provider staff must complete this form when a child's healthcare concern (e.g., fever, reported history of seizures, challenges with activities of daily living such as walking or eating, exposure to varicella) is triaged with a licensed healthcare professional or treated with an over the counter (OTC) medication per the child's standing order. **REMINDER:** Anytime a child's symptoms meet ORR's definition of a medical emergency (See UAC Policy 3.4.5), the child **must** immediately receive emergency care.

General Info

Last name:		First name:	DOB:
A#:	Allergies:		
Current ORR program:		Name & role of staff completing form:	

Healthcare Concern

Reporting source: • Child • Care provider staff • Foster parent • Family/Sponsor • ORR • Other, specify: _____
Date/Time Reported/Observed: ____ / ____ / ____, ____:____ (24 hr) **Date/Time Report Received:** ____ / ____ / ____, ____:____ (24 hr)
Report details:

For infectious disease exposures that require a contact investigation, per ORR, specify illness: _____
Source of exposure: _____ **Date of first exposure:** ____ / ____ / ____ **Date of last exposure:** ____ / ____ / ____

Onsite Health Intervention

Additional clinical info learned through child interview, if performed:

Was the concern triaged by a licensed healthcare professional? • No • Yes, specify date ____ / ____ / ____, and time: ____:____ (am/pm)
Name of healthcare professional/triage service & credentials: _____ **Setting:** • In-person • Remote
Instructions from healthcare professional, including the timeframe for following up if symptoms do not improve, worsen, or recur:

Was OTC medication administered? • No • Yes, specify source: • Triage instructions • Standing order
For medications administered per the child's standing order only (no triage), specify medication(s) and instructions related to this concern:

Was child separated from general population? • No • Yes, specify type of separation: • Quarantine • Isolation
If 'Yes', specify start date & time (24 hr): ____ / ____ / ____, ____:____ and **end date & time (24 hr):** ____ / ____ / ____, ____:____

Post-Intervention Status

Child's status after all onsite health interventions were completed (not including healthcare provider (HCP) evaluations):

- Improved or resolved/Cleared from quarantine
- Unresolved/Developed symptoms in quarantine; next steps: • Emergency care • Schedule HCP visit (MAF required)
- Unknown/Lost to follow-up; specify reason: _____

Date and time child's post-intervention status was determined: ____ / ____ / ____, ____:____ (24 hr)

Additional Information (e.g., post-triage HCP consultation outcome, follow-up appointment date and time):