

Page 1 of 4

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 <u>at IME</u>	• Blood/Serum	• Ordered	• Pending; collected: ____/____/____			
Lead	<6 yrs, lactating or pregnancy <u>at IME</u>	• 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 <u>at IME</u> , sexual activity/abuse/assault	• Urine pregnancy	• Negative	• Positive	• Indeterminate		
HIV	All children <u>at IME</u>	• Rapid, fingerstick/oral	• Negative	• Positive	• Indeterminate		
		• Blood/Serum, 4 th Gen	• Ordered	• Pending; collected: ____/____/____			
Syphilis	<2 yrs & not with biological mother <u>at IME</u> , 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	<u>Any</u> 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 Disease (Non-TB):	Specify: _____		• Ordered	• Pending; collected: ____/____/____			
	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 <u>or</u> 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	HEENT	Respiratory/Pulmonary	Cardiovascular	Gastrointestinal		
• Allergic reaction • Allergy: _____ • Anemia • Dehydration • Developmental delay • Lead in blood • Fatigue • Lymphadenopathy • Obesity • Sick cell disease • Underweight/Weight loss • Other: _____	• Allergic rhinitis • Cerumen impaction • Conjunctivitis • Hearing issues: _____ • Otitis externa • Otitis media • Pharyngitis, strep • Pharyngitis, other • Vision issues: _____ • Other: _____	• 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: _____	• Arrhythmia • Chest pain • Congenital heart disease: _____ • High blood pressure • Heart murmur • Myocarditis/Pericarditis/Endocarditis • Syncope/Fainting • Other: _____	• 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		Endocrine Disorder				
• Broken tooth/teeth • Gingivitis/Gum disease • Impacted tooth/teeth • Infection/abscess		• Acanthosis nigricans • Delayed/Precocious puberty • Diabetes, Type 1 and 2		• Hyper/Hypothyroidism • Short stature • Other: _____		
Genito-urinary/Reproductive		Musculoskeletal	Potentially Reportable Infectious Disease			
• 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: _____		• Back pain • Bone tumors (benign/malignant) • Extremity/Joint pain • Fracture • Hematoma/Bruise • Ligamentous/Tendon injury • Myalgia • Scoliosis/Kyphosis • Sprain/Strain • Other: _____		
				• Acute hepatitis A • Acute/chronic hepatitis B • Acute/chronic hepatitis C • Chikungunya • Chlamydia • COVID-19 • Dengue • Gonorrhea • HIV • Malaria • Measles • Mumps		
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: _____

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. Public reporting burden for this collection of information is estimated to average 13 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 0970-0466 and the expiration date is 10/31/2026. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.