U.S. Department of State
Bureau of Medical Services, M/MED, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 08-31-2020
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
FOR CHILDREN AGE 11 AND YOUNGER

PRIVACY ACT NOTICE

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (Title 22 U.S.C.4084).
PURPOSE: The information solicited on this form will be used to make appropriate medical clearance decisions.
ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. More information on routine uses can be found in the System of Records Notice State-24, Medical Records.
DISCLOSURE: Providing this information is voluntary; however, not providing requested information may result in the failure of the individual to obtain the requisite medical clearance pursuant to 16 FAM 211.

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and /or recommendation for reducing it, please send them to: M/MED/EX, Room L101 SA-1, U.S. Department of state, Washington, DC 20522

I. DEMOGRAPHIC INFORMATION
TO BE FILLED OUT BY EMPLOYEE/SPONSOR OR PARENT

DATE OF EXAM *(mm-dd-yyyy)*

1. Name of Examinee *(Last, First, MI)*

2. Date of Birth *(mm-dd-yyyy)*

3. Sex ☐ Male ☐ Female

4. Full Name of Employee/Applicant/Sponsor

5. eMED Number if known (*Employee/Applicant/Sponsor*)

6. Place of Birth

City _____ State _____ Country _____

7. Foreign Service Agency of Employee/Applicant/Sponsor

☐ STATE ☐ USAID ☐ Foreign Commercial Service ☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

8. E-mail Address of Parent/Sponsor
(Where You can be Reached for the Next 90 days)

9. Purpose of Exam

☐ New Dependent (*pre-employment, newborn, adoption*)
☐ In-Service Exam
☐ Separation

10. Telephone Number of Employee/Applicant *(parent)*
(Where You can be Reached for the Next 90 days)

12. Mailing Address
(Where You can be Reached for the Next 90 days)

13. Post of Assignment and Estimated Dates of Arrival / Departure

a. Proposed Post _____ EDA _____ *(mm-dd-yyyy)*

b. Present Post _____ EDD _____ *(mm-dd-yyyy)*

c. Last 3 Posts _____

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of Examinee	DOB

II. MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS: *For YES answers, provide a brief explanation, attach additional sheets, if needed.*

Does your child currently, or have a hisory of:

Yes	No		
☐	☐	1.	Frequent/severe headaches?
☐	☐	2.	Fainting or dizzy episodes?
☐	☐	3.	Seizures or neurologic disorders?
☐	☐	4.	Chronic eye or vision problems?
☐	☐	5.	Ear, nose, or throat problems, including hearing loss?
☐	☐	6.	Allergies or history of anaphylactic reaction?
☐	☐	7.	Cough, wheeze, shortness of breath, asthma?
☐	☐	8.	Heart murmur or heart problems?
☐	☐	9.	Rheumatic fever?
☐	☐	10.	Diabetes or thyroid disorder?
☐	☐	11.	Hormonal or metabolic disorder?
☐	☐	12.	Stomach, esophageal, intestinal problems?
☐	☐	13.	Liver or gallbladder problems. Hepatitis?
☐	☐	14.	Intestinal, rectal problems or hernia?
☐	☐	15.	Anemia?
☐	☐	16.	Blood transfusions?
☐	☐	17.	Urinary or kidney problems, blood in urine?
☐	☐	18.	Cancer of any type?

Yes	No		
☐	☐	19.	Joint, tendon or any orthopedic disorder?
☐	☐	20.	Rheumatologic or immune disorder?
☐	☐	21.	Malaria or other tropical disease?
☐	☐	22.	Any recent unexpected weight loss/gain?
☐	☐	23.	Any skin or nail disorder
☐	☐	24.	History of Tuberculosis TB exposure?

Yes	No	
☐	☐	25. Has your child been referred for any current or potential special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)?
☐	☐	26. In the past seven years, has your child been in psychotherapy/counseling or been prescribed medication to help with depression, anxiety, mood or stress?
☐	☐	27. Has your child felt unusually depressed, sad, blue, or had frequent crying spells which lasted more than 2 weeks at a time, within the past seven years?
☐	☐	28. In the past seven years, has your child had frequent or recurrent episodes of: difficulty relaxing or calming down, panicky feelings, irritability, anger, feeling hyper, or nervousness?
☐	☐	29. In the past seven years, has your child experienced any emotional or physical symptoms related to a past trauma?

30. Is there anything else you would like to add about your child's health or well being that was not addressed in questions 1-29? ☐ Yes ☐ No

II a. Explanation required for "yes" answers to questions 1-30. Attach additional sheets as needed

III. LIST OF CURRENT MEDICATIONS *(Include prescription, over the counter, vitamins, and herbs)*	**Drug Or Other Allergies**

IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS *(Include all medical and psychiatric illnesses)*

Date *(mm-dd-yyyy)*	Illness or Operation	Name of Hospital	City and State

Any knowing and willful omission, falsification, or fraudulent statement regarding material medical information may constitute a criminal offense under 18 U.S.C. § 1001, and individuals committing such an offense may be subject to criminal prosecution. Employees of the United States Government also may be subject to disciplinary action, up to and including separation, for any knowing and willing omission or falsification or fraudulent statement of material information.

V. SIGNATURE OF PARENT OR SPONSOR *(I certify I have read and understand the above statement.)*

	Date *(mm-dd-yyyy)*

Name of Examinee	DOB

VI. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DS-1622

MEDICAL EXAMINER

- Medical Examiner must comment on positive history on page 2. Medical Examiner must comment on physical findings and provide recommendations for treatment/further study/consultations of medical & mental health problems.
- Medical Examiner must sign on page 4.

EMPLOYEE SPONSOR / PARENT

- All fields on page 1 and 2 must be filled out. Employee sponsor or parent must sign on page 2.
- Submit copies of all laboratory tests and additional medical reports with DS-1622.
- All Lab tests and medical reports must be in English, and identified with full name and date of birth of examinee.
- Keep originals as a permanent record. Do NOT submit by U.S. Mail or by courier service (e.g. FedEx or DHL).

The preferred method to submit the DS - 1622 (and supporting documentation) is to scan and email in PDF format to: **MEDMR@state.gov**. If it is not possible to scan, please fax to Medical Records department **FAX: 202-647-0292**

If you wish to confirm that your exam forms were received, please email **MEDMR@state.gov**.

VII. Medical Examiner comments on significant patient medical history and items checked "yes" on page 2 / section II. Use additional pages if needed.

VIII. CLINICAL EVALUATION: ***Newborn exam cannot be accepted if completed before four (4) weeks of age***

1. Height/Length	2. Weight	**3.Pulse or HR (REQUIRED FOR ALL AGES and NEWBORNS) RECORD**	4. Blood Pressure *(age 3 and Over)*
_____ in. or	_____ lb. or		
_____ cm.	_____ kg.		
_____ percentile	_____ percentile		

5. Head Circumference *(18 months and under)*	6. Development Appropriate for Age ☐ Yes ☐ No If NO, attach Development Screen and explain below with detail in assessment / plan
_____ in. or	7. Gestational age at birth
_____ cm.	
_____ percentile	8. Immunizations Reviewed ☐ Yes ☐ No Immunizations current? ☐ Yes ☐ No

IX. PHYSICAL EXAM Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	**Notes** *(Describe each abnormality in detail.)*
1. General/Constitution				
2. Development				
3. Skin				
4. Eyes				
5. Ears/Nose/Throat				
6. Neck/Thyroid				
7. Lungs/Thorax				
8. Cardivascular (*Record murmurs/abnormalities*)				
9. Abdomen				
10. Genitalia				
11. Anus/Rectum				
12. Musculoskeletal/Spine/ Extremities (*Note limitations*)				
13. Lymph nodes				
14. Neurologic				

Name of Examinee	DOB

X. LABORATORY ANALYSIS

NO LABORATORY TESTS REQUIRED FOR INFANTS
For ages 1 year and above, all tests are required unless otherwise specified. Results from previous 12 months are acceptable.
COPIES OF LABORATORY REPORTS MUST BE SUBMITTED FOR REVIEW AND MUST BE IN ENGLISH

1. Hematology *(age 1 and over)* Hematocrit _____ % **OR** Hemoglobin _____ gms%

2. Urinalysis *(only when indicated)* WBC _____ RBC _____ Protein _____ Glucose _____ Other _____

3. Tuberculin Skin Test*: Required for ages 1 and over (unless previously positive)*

Results: _____ mm of induration Date: _____

Interferon Gamma Release Assay: (may substitute for TST if > 5 y/o or In those with previous BCG)

Results: _____ Date: _____

If no TB screening performed, explain why:

Previous active tuberculosis ☐ Yes ☐ No Date: _____

Previous positive TST or IGRA ☐ Yes ☐ No Date: _____

Previous LTBI treatment ☐ Yes ☐ No Date: _____

Hx of BcG vaccine ☐ Yes ☐ No Date: _____

Other: _____

4. Chest X Ray *(PA and lateral)* - submit report

- **Required only for children with > 10 mm TST newly identified or positive IGRA**

OR

- **When clinically indicated**

Results: _____

Date: _____

OPTIONAL TESTS*: The following tests may be performed at the discretion of the Examiner, with patient consent. They are not required for a medical clearance determination. If performed, results may be used in the provision of care to individuals covered under the Department of State Medical Program.*

5. Blood Type *(if not previously documented)* Type: ABO _____ (Rh) Dμ: _____ (weak D): _____

6. G6PD *(If not previously documented)* for malarial prophylaxis Results: _____ Date: _____

7. Blood lead level *(recommended screening ages 12 months to 5 years)* Results: _____ Date: _____

XI. Assessment or Problem List	XII. Recommendation for Treatment / Further Study / Consultation or Follow - Up

Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)

Examining Facility	Telephone Number

Address