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: 04-30-2026
ESTIMATED BURDEN: 1 HOUR

# MEDICAL HISTORY AND EXAMINATION
## FOR CHILDREN AGE 11 AND YOUNGER

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

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

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

1b. Chosen Name of Examinee

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

3. Sex
☐ Female ☐ Male

4. Place of Birth
City _____ State _____ Country _____

5. Full Name of Employee/Applicant/Sponsor

6. Agency of Employee/Applicant/Sponsor
☐ STATE ☐ USAID ☐ FCS ☐ FAS ☐ U.S. Agency for Global Media ☐ DoD Civilian ☐ DoD Contractor
☐ Other Federal Agency _____ ☐ Contracting Company _____

7. E-mail Address of Parent/Sponsor
*(Where You can be Reached for the Next 90 days)*
Primary: _____
Alternate: _____

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

9. Telephone Number of P*arent/Sponsor*
*(Where You can be Reached for the Next 90 days)*
Primary: _____
Alternate: _____

10. Post of Assignment and Estimated Dates of Arrival / Departure
a. Proposed Post _____ EDA _____ *(mm-dd-yyyy)*
b. Present Post _____ EDD _____ *(mm-dd-yyyy)*

**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

ANSWER THE FOLLOWING QUESTIONS: ALL YES ANSWERS MUST HAVE A WRITTEN EXPLANATION WITH DATE OF OCCURENCE IN BOX IIA.

### Does examinee currently, or have a history of:

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Frequent/severe headaches? |
| ☐ | ☐ | 2. Fainting, dizzy episodes, or syncope? |
| ☐ | ☐ | 3. Seizures or neurologic disorders? |
| ☐ | ☐ | 4. 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. Murmurs, palpitations, or other heart problems? |
| ☐ | ☐ | 9. Rheumatic fever? |
| ☐ | ☐ | 10. Diabetes, thyroid, or other endocrine disorders? |
| ☐ | ☐ | 11. Hormonal or metabolic disorder? |
| ☐ | ☐ | 12. Stomach, esophageal, or other intestinal problems? |
| ☐ | ☐ | 13. Jaundice, hepatitis, gallbladder or other liver disease? |
| ☐ | ☐ | 14. Intestinal, rectal problems or hernia? |
| ☐ | ☐ | 15. Anemia? |
| ☐ | ☐ | 16. Blood transfusions? |
| ☐ | ☐ | 17. Urinary or kidney problems, blood in urine? |
| ☐ | ☐ | 18. Cancer of any type? |
| ☐ | ☐ | 19. Premature birth, pre or post-natal complications? |
| ☐ | ☐ | 20. Joint, tendon or any orthopedic disorder? |
| ☐ | ☐ | 21. Rheumatologic or immune disorder? |
| ☐ | ☐ | 22. Malaria, tropical or other infectious disease? |
| ☐ | ☐ | 23. Any recent unexpected weight loss/gain? |
| ☐ | ☐ | 24. Any skin or nail disorder |
| ☐ | ☐ | 25. History of positive TB skin test, IGRA, or Tuberculosis? |

### IN THE PAST TWO (2) YEARS (for question 26-34)

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 26. Has your child been referred or evaluated for any special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)? |
| ☐ | ☐ | 27. Has your child ever been in in psychotherapy or counseling/coaching for the treatment of anxiety, depression/mood problems, psychological trauma, or any other mental health or behavioral health concerns? |
| ☐ | ☐ | 28. Has your child ever been prescribed medication for depression, anxiety, mood, or stress, attention, autism, or any other mental health or behavioral health symptoms? |
| ☐ | ☐ | 29. Has your child ever been diagnosed with an alcohol or drug-related problem, been medically advised to reduce use of a substance, or experienced a negative consequence due to substance use, such as a legal infraction, medical or school problems? |
| ☐ | ☐ | 30 Has your child ever experienced symptoms of an eating disorder, such as a history of binging, purging by self-induced vomiting or use of laxatives, diuretics or enemas, or restriction of food leading to extreme weight loss or medical symptoms? |
| ☐ | ☐ | 31. Has your child ever Engaged in self-harm or suicidal behavior? |
| ☐ | ☐ | 32. Has your child ever been hospitalized or in a partial hospital, day-treatment or residential treatment for a mental health or behavioral health condition, or engaged in self-injury or suicidal behavior? |
| ☐ | ☐ | 33. Are you interested in a consultation with a Mental Health specialist on managing Mental Health treatment overseas? |
| ☐ | ☐ | 34. Is there anything else you would like to add about your child's health or well-being that was not addressed in questions 26-33? |

**IIA. Explanation required for "yes" answers to questions 1-34. Attach additional document.**

| Name of Examinee | | | DOB |
|---|---|---|---|
| | | | |

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

| | | | Drug Or Other Allergies |
|---|---|---|---|
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**IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS** *(Include all medical and psychiatric illnesses)*

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

**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 from this form will assist in making a medical clearance decision for individuals eligible to participate in the Department of State Medical Program while assigned abroad. (16 FAM 100 - 200)
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.

| Name of Examinee | | | DOB |
|---|---|---|---|
| | | | |

## VI. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DS-1622

**MEDICAL EXAMINER**

- Medical Examiner must comment on positive history (pg. 2), abnormal physical findings (pg. 4), and provide follow-up recommendations (pg. 5).
- Medical Examiner must sign on page 5.

**EMPLOYEE SPONSOR / PARENT**

- All fields on pages 1-3 must be filled out. Examinee or parent/employee sponsor must sign on page 3.
- 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).

Submit the DS-1622 and other documentation via email in PDF format to MEDMR@state.gov (preferred), or by fax to the Medical Records Department at 202-647-0292.

## 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, INCLUDING, NEWBORNS) | 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<br>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<br>Immunizations current? ☐ Yes ☐ No |

| IX. PHYSICAL EXAM<br>Check each item as indicated.<br>Check "NE" if not evaluated. | Normal | Abnormal | NE | Notes<br>*(Describe each abnormality in detail. Include pertinent item number before each comment)* |
|---|---|---|---|---|
| 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. TUBERCULOSIS SCREENING

**1. Tuberculin Skin Test** : **REQUIRED** *for ages 1 and over (unless previously positive)*
For baseline status in a child who will live overseas in a likely endemic TB area.

TST Results: _____ mm of induration Date: _____

IGRA Results: _____ Date: _____
*Interferon Gamma Release Array*: (may substitute for TST if > 5 y/o or In those with previous BCG)

| | | | |
|---|---|---|---|
| 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: _____ |

**2. Chest X Ray** *(PA and lateral)* **- Required only if TST > 10mm, positive IGRA or clinically indicated.**

**SUBMIT REPORT**

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) |
|---|---|---|
| | | |

| Address | Telephone Number |
|---|---|
| | |