U.S. Department of State

Office of Medical Services, Room L209, SA-1, Washington, DC 20522-0102

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

For children 11 years and under

***OMB APPROVAL NO. 1405-0068**
EXPIRATION DATE: 09-30-2005
ESTIMATED BURDEN: 1 HOUR

PRIVACY ACT NOTICE:
This information is requested pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. 3084, 3901 and 3984). The primary purpose for soliciting this information is to determine medical eligibility to enter the Foreign Service and to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether federal, state, local or foreign, for law enforcement and administration purposes. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

I. TO BE FILLED OUT BY SPONSOR OR PARENT (complete all sections, type or in ink).

DATE *(mm-dd-yyyy)*

1. NAME OF EXAMINEE *(Last, First, Middle)*

2. FULL NAME OF EMPLOYEE/APPLICANT/SPONSOR

3. DATE OF BIRTH *(mm-dd-yyyy)*

4. SEX
☐ MALE ☐ FEMALE

5a. AGENCY OF EMPLOYEE/APPLICANT/SPONSOR
☐ State ☐ USAID ☐ Other ____________

5b TYPE OF EMPLOYMENT
☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

6. SOCIAL SECURITY NUMBER *(Employee/Applicant/Sponsor)*

7. PLACE OF BIRTH

City ____________________ Country ____________________

8. POST OF ASSIGNMENT AND DATES OF DEPARTURE/ARRIVAL

a. Proposed Post ____________ EDA ____________

b. Present Post ____________ EDD ____________

c. Last 3 Posts ____________
____
____

9. MAILING ADDRESS
(Medical Clearance Abstract will be mailed to listed address)

____
____
____

TELEPHONE NO.
(where you can be reached for the next 90 days) ____________________

E-MAIL ADDRESS
(where you can be reached for the next 90 days) ____________________

10. NAME OF YOUR HEALTH INSURANCE PLAN

11. PURPOSE OF EXAMINATION
☐ a. Preemployment ☐ b. In-Service ☐ c. Separation ☐ d. New Dependent

12. IS CHILD ADOPTED? ☐ YES ☐ NO

CHECK AND DESCRIBE MEDICAL CONDITIONS OF BLOOD RELATIVES. INCLUDE SICKLE CELL DISEASE, CANCER, ALCOHOLISM, HEART DISEASE, HIGH CHOLESTEROL, KIDNEY DISEASE, HIGH BLOOD PRESSURE, ASTHMA, MENTAL HEALTH PROBLEM OR LEARNING DISABILITY.

☐ Father ____________________
☐ Mother ____________________
☐ Grandmother(s) ____________________
☐ Grandfather(s) ____________________
☐ Sisters ____________________
☐ Brothers ____________________
☐ Aunts ____________________
☐ Uncles ____________________

DO NOT WRITE IN THE SPACE BELOW (FOR USE BY MEDICAL DIVISION ONLY)

IMIMS #:

CLEARANCE ACTION:

*Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

II. HAVE YOU EVER HAD:

NAME OF EXAMINEE:

YES	NO	
☐	☐	1. Frequent or severe headaches?
☐	☐	2. Dizzy spells, fainting, or blackouts?
☐	☐	3. Epilepsy or seizures?
☐	☐	4. Eye trouble or vision problems?
☐	☐	5. Any neurological disorder?
☐	☐	6. Tooth or gum problems?
☐	☐	7. Difficulty with your hearing?
☐	☐	8. Other ear, nose, or throat problems?
☐	☐	9. Hayfever or other allergies?
☐	☐	10. Asthma, wheezing or chronic cough?
☐	☐	11. Trouble catching your breath?
☐	☐	12. Heart murmur or heart problems?
☐	☐	13. Rheumatic fever?
☐	☐	14. Stomach, liver, or intestinal problems?
☐	☐	15. Jaundice or hepatitis?
☐	☐	16. Bedwetting after age 3?
☐	☐	17. Bowel or bladder daytime accidents?
☐	☐	18. Kidney trouble; stone, blood in urine?
☐	☐	19. Bladder infections?
☐	☐	20. Sugar or protein in urine?
☐	☐	21. Diabetes?
☐	☐	22. Arthritis or joint pains?

YES	NO	
☐	☐	23. Joint or bone deformity or fracture?
☐	☐	24. Malaria or other tropical disease?
☐	☐	25. Any skin problems?
☐	☐	26. Growth pattern abnormality?
☐	☐	27. Tuberculosis or exposure to tuberculosis?
☐	☐	28. A blood transfusion?
☐	☐	29. Anemia?
☐	☐	30. Frequent crying spells?
☐	☐	31. Sadness or withdrawal?
☐	☐	32. Trouble sleeping?
☐	☐	33. Fears or worries?
☐	☐	34. Difficulty in relaxing or calming down?
☐	☐	35. Change in academic functioning?
☐	☐	36. Low academic functioning?
☐	☐	37. Difficulty with attention or focusing?
☐	☐	38. Learning disability or disorder?
☐	☐	39. If #38 is yes, past or current Individualized Education Plan (IEP)?
☐	☐	40. Speech delay or other speech problem?
☐	☐	41. Behavioral or discipline problem at home or school?
☐	☐	42. Have you ever had a consultation, evaluation or treatment by a mental health professional (psychiatrist, psychologist, social worker, or counselor) or been a patient in a mental health facility?

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

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

Anything else you would like to mention about your child's health or well being? Parent should explain "yes" answers to questions 30-42.

Please Recheck All Items for Completeness and Accuracy. DO NOT INDICATE: "Previously Answered."

The intentional omission of any crucial medical information is a criminal offense (Section 1001 of the U.S.C. Title 18). Preemployment applicants who intentionally omit information which would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause if they are hired. Current employees may also be subject to disciplinary action for intentional omission of information.

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

DATE *(mm-dd-yyyy)*

V. TO BE COMPLETED BY THE EXAMINER *(Read Section X Before Proceeding)*

SIGNIFICANT HISTORY: *(NOTE: The Examiner MUST comment on ALL items checked "YES" in Part II).*

VI. TO BE COMPLETED BY THE EXAMINER	NAME OF EXAMINEE:			
1. RACE *(check one)* *(need for genetic risk factors)* ☐ White ☐ Black ☐ Other *(specify)* ______	**2. HEIGHT** ______ in. or ______ cm. ______ percentile	**3. WEIGHT** ______ lb. or ______ kg. ______ percentile	**4. PULSE** *(must be recorded)*	**5. BLOOD PRESSURE** *(age 5 and Over)*

6. DISTANT VISION *(age 5 and Over)*	**7. HEAD CIRCUMFERENCE** *(18 months and under)*	**8. DEVELOPMENT APPROPRIATE FOR AGE** Yes ☐ No ☐
Right 20/ Corrected 20/	______ in. or	Attach developmental screen if indicated under age 4
Left 20/ Corrected 20/	______ cm.	**9. IMMUNIZATIONS REVIEWED** Yes ☐ No ☐ Immunizations current? Yes ☐ No ☐

VII. CLINICAL EVALUATION Check each item as indicated. Enter "NE" if not evaluated.	Normal	Abnormal	**NOTES** *(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)*
1. Skin *(Record Lesions Body Marks and Surgery Scars)*			
2. Head, Neck and Thyroid			
3. Ear, Nose and Throat *(Gross Hearing Evaluated)*			
4. Lymph Nodes			
5. Eyes			
6. Lungs			
7. Breast			
8. Heart *(Record Murmurs and Abnormalities)*			
9. Abdomen			
10. Genitalia *(Male-Testes Descended?)*			
11. Anus			
12. Vascular System *(Record Peripheral Pulses)*			
13. Extremities, Hips and Spine *(scoliosis)*			
14. Neurological *(Record Reflexes, Muscle Strength and Gait)*			
15. Psychiatric *(Specify Any Significant Mood, Cognitive,*			

ADDITIONAL COMMENTS

VIII. ALL OF THE FOLLOWING TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED *(No LAB required for newborns)*

1. HEMATOLOGY *(age 1 and over)*

Hematocrit ______ %

2. URINALYSIS *(preemployment age 1 and over, separation and*

- Specific Gravity ______
- Albumin ______
- Sugar ______
- WBC ______
- RBC ______
- Casts ______
- Other ______

3. BLOOD LEAD LEVEL *(recommended for ages 9 mo. up to 6 years)*

______

4. CHEST X-RAY *(for new TB skin test convertors, or when indicated).*

______
Date *(mm-dd-yyyy)*

______
Results:

5. TUBERCULIN TEST *(5TU PPD)* *(recommended for all ages 1 and over, including those with previous BCG)*

Date *(mm-dd-yyyy)* ______

Results: ______ mm of induration

Previous BCG Yes ____ No ____

Previous Positive Yes ____ No ____

Previous Rx completed Yes ____ No ____

Date completed *(mm-dd-yyyy)* ______

New Converter *(XRay required)* Yes ____ No ____

Treatment:

6. PREEMPLOYMENT ONLY *(or if previously not done)*

a. Blood Type
- ABO ______
- (Rh) D ______
- (weak) D^u ______

b. G6PD
- Normal ______
- Deficient ______

NAME OF EXAMINEE:		
IX. ASSESSMENT OR PROBLEM LIST	**RECOMMENDATION FOR TREATMENT/FURTHER STUDY**	
TYPED NAME OF EXAMINER	SIGNATURE	DATE *(mm-dd-yyyy)*
EXAMINING FACILITY AND TELEPHONE NUMBER	ADDRESS	

X. INSTRUCTIONS TO THE EXAMINER

IMPORTANCE OF EXAMINATION: IT IS IMPORTANT FOR THE EXAMINER TO IDENTIFY ALL MEDICAL CONDITIONS WHICH WILL REQUIRE FOLLOW-UP MEDICAL CARE OR COULD BE ADVERSELY AFFECTED BY ENVIRONMENTAL CONDITIONS SUCH AS HIGH ALTITUDE, AIR POLLUTION, AND POOR SANITATION. The consequences of not identifying preexisting health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be assigned to a third world developing country where medical care is not available.

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DISPOSITION OF REPORTS: All reports must be in English and be identified with the full name and date of birth of the examinee, All reports should be placed in a sealed envelope and marked, "Privileged Medical Information." If abroad, the report should be returned to the Embassy. If in the U.S., the report should be mailed to: MEDICAL CLEARANCES, Room L209, SA-1, U.S. Department of State, 2401 E St. NW Washington, DC 20522-0102.

EXAMINATION FEES: Reimbursement of a reasonable and customary fee will be made for each examination, including laboratory tests, and X-ray procedures. Please itemize tests and cost of each. Submit first to insurance and any remaining bills to: Medical Claims, Room H-230, SA-1, U.S. Department of State 2401 E St. NW, Washington DC 20522-0102.

NOTE: Recommend that a copy of examination be given to examinee.