U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 5-31-2009
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

FOR CHILDREN 11 YEARS AND UNDER

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 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, MI.)*

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 _____

6. Social Security Number *(Employee/Applicant/Sponsor)*

5b. Type of Employment ☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

7. Place of Birth

City _____ State _____ Country _____

8. Post of Assignment and Dates of Departure/Arrival

a. Proposed Post _____

EDA _____ *(mm-dd-yyyy)*

b. Present Post _____

EDD _____ *(mm-dd-yyyy)*

c. Last 3 Posts _____

9. Mailing Address
(Medical Clearance Abstract will be mailed to listed address)

_____

_____

_____

Telephone Number *(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. Pre-Employment ☐ 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) _____
☐ Sister(s) _____
☐ Brother(s) _____
☐ Aunt(s) _____
☐ Uncle(s) _____

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

Clearance Action

***Public reporting burden for this collection of information is estimated to average 1 hour 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:**

II. Have You Ever Had:	Name of Examinee

Yes	No		Yes	No	
☐	☐	1. Frequent or severe headaches?	☐	☐	13. Rheumatologic problems; tendon, joint or back pain/injury; bone deformity or fracture?
☐	☐	2. Dizzy spells, fainting, or seizures?	☐	☐	14. Malaria or other tropical disease?
☐	☐	3. Any neurological disorder?	☐	☐	15. Any hair, nail or skin problems or disorders?
☐	☐	4. Chronic eye trouble or vision problems? Date of last eye exam: _____	☐	☐	16. History of positive TB skin test or clinical tuberculosis/ TB exposure or BCG vaccination?
☐	☐	5. Tooth or gum problems?	☐	☐	17. Anemia or blood transfusion?
☐	☐	6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?	☐	☐	18. Recent gain or loss of 10 lbs or more?
☐	☐	7. Cough, wheezing, shortness of breath or asthma?	☐	☐	19. Frequent crying spells, trouble sleeping, sadness, withdrawal, fears, or worries?
☐	☐	8. Heart murmur or heart problems?	☐	☐	20. Difficulty in relaxing or calming down; feelings of confusion?
☐	☐	9. Rheumatic fever?	☐	☐	21. Low academic functioning or learning disability or disorders?
☐	☐	10. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?	☐	☐	22. Behavioral or discipline problems at home or school?
☐	☐	11. A change in urinary habits, urinary tract infection, bedwetting or stones, blood or protein in urine?	☐	☐	23. Have you ever been referred to or received mental health treatment?
☐	☐	12. Diabetes; thyroid or other hormonal/ metabolic disease?	☐	☐	24. Other?

III. List Current Medications *(Include prescription, over the counter, vitamins, and herbals)*		Drug Or Other Allergies	

IV. Hospitalizations/Operations/Medical Evacuation *(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 1-24.

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)*. Pre-employment applicants who intentionally omit information that 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)*	2. Height	3. Weight	4. Pulse *(must be recorded)*	5. Blood Pressure *(age 5 and Over)*
☐ White ☐ Black ☐ Other *(specify)* _____	_____ in. or _____ cm. _____ percentile	_____ lb. or _____ kg. _____ percentile		

6. Distant Vision *(age 5 and Over)*	7. Head Circumference *(18 months and under)*	8. Development Appropriate for Age
Right 20/ Corrected 20/	_____ in. or	☐ Yes ☐ No
Left 20/ Corrected 20/	_____ cm.	Attach development screen if indicated under age 4
		9. Immunizations Reviewed ☐ Yes ☐ No
		Immunizations current? ☐ Yes ☐ No

VII. Clinical Evaluation Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	**Notes** *(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)*
1. General/Constitution	☐	☐	☐	
2. Skin	☐	☐	☐	
3. Eyes	☐	☐	☐	
4. Ears/Nose/Throat	☐	☐	☐	
5. Neck/Thyroid	☐	☐	☐	
6. Lungs/Thorax	☐	☐	☐	
7. Breasts	☐	☐	☐	
8. Cardiovascular	☐	☐	☐	
9. Abdomen	☐	☐	☐	
10. Male Genitalia	☐	☐	☐	
11. Anus/Rectum/Prostate	☐	☐	☐	
12. Musculoskeletal	☐	☐	☐	
13. Lymphatic	☐	☐	☐	
14. Neurological	☐	☐	☐	
15. Female Gynecologic	☐	☐	☐	
16. Miscellaneous				
17. Papanicolaou done ☐ Not done ☐ Reason if not done				
18. Attach cytology report.				

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 when indicated).*

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. Pre-employment 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 requiring follow-up medical care or that 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.

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 Records, Room L101, 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 then any remaining bills to: Medical Claims, Room L101, 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.