



U.S. Department of State
Office of Medical Services, Room L209, SA-1, Washington, D.C. 20522-0102
MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
For children 11 years and under

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 08-31-2002
ESTIMATED BURDEN: 1 HOUR

PRIVACY ACT NOTICE: This information is requested under the authority of section 101 (22 U.S.C. 3901), 504 (22 U.S.C. 3984) and 904 (22 U.S.C. 3084) of the Foreign Service Act of 1980, as amended, to assist the Office of Medical Services in determining your medical clearance status for employment or service abroad. Failure to provide this information may result in a determination not to grant a medical clearance and effect your eligibility for the Foreign Service. Medical records are used only routinely by medical and administrative personnel of the Office of Medical Services as necessary to operate the medical program. Your medical records can be released to third parties only with your written permission under the conditions specified in 5 U. S. C. 552a(b) and in accordance with the uses permitted for the U.S. Department of State Medical Records System, STATE-24. See 41 Fed. Reg. 41330, 41342 (Sept. 21, 1976), 48 Fed. Reg. 19809-10 (May 2, 1983), and www.access.gpo.gov for subsequent amendments in the Federal Register (i.e., annual Privacy Act Issuances, State Department, State-24).

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
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3. DATE OF BIRTH (mm-dd-yyyy)	4. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	5a. AGENCY OF EMPLOYEE/APPLICANT/SPONSOR <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Other _____
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6. SOCIAL SECURITY NUMBER (Employee/Applicant /Sponsor)	5b. TYPE OF EMPLOYMENT <input type="checkbox"/> Foreign Service Officer <input type="checkbox"/> Contractor <input type="checkbox"/> Civil Service Excursion Tour
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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 _____ _____
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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
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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:

VI. TO BE COMPLETED BY THE EXAMINER		NAME OF EXAMINEE:		
1. RACE (check one) <i>(need for genetic risk factors)</i> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other <i>(specify)</i>	2. HEIGHT _____ in. or _____ cm. _____ percentile	3. WEIGHT _____ lb. or _____ kg. _____ percentile	4. PULSE (must be recorded)	5. BLOOD PRESSURE <i>(age 5 and Over)</i>
6. DISTANT VISION (age 5 and Over) Right 20/ Corrected 20/ Left 20/ Corrected 20/		7. HEAD CIRCUMFERENCE <i>(18 months and under)</i> _____ in. or _____ cm.	8. DEVELOPMENT APPROPRIATE FOR AGE Yes <input type="checkbox"/> No <input type="checkbox"/> Attach developmental screen if indicated under age 4	
		9. IMMUNIZATIONS REVIEWED Yes <input type="checkbox"/> No <input type="checkbox"/> Immunizations current? Yes <input type="checkbox"/> No <input type="checkbox"/>		
VII. CLINICAL EVALUATION		Normal	Abnormal	NOTES <i>(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)</i>
Check each item as indicated. Enter "NE" if not evaluated.				
1. Skin <i>(Record Lesions Body Marks and Surgery Scars)</i>				
2. Head, Neck and Thyroid				
3. Ear, Nose and Throat <i>(Gross Hearing Evaluated)</i>				
4. Lymph Nodes				
5. Eyes				
6. Lungs				
7. Breast				
8. Heart <i>(Record Murmurs and Abnormalities)</i>				
9. Abdomen				
10. Genitalia <i>(Male-Testes Descended?)</i>				
11. Anus				
12. Vascular System <i>(Record Peripheral Pulses)</i>				
13. Extremities, Hips and Spine <i>(scoliosis)</i>				
14. Neurological <i>(Record Reflexes, Muscle Strength and Gait)</i>				
15. Psychiatric <i>(Specify Any Significant Mood, Cognitive, Behavioral Observations)</i>				
ADDITIONAL COMMENTS				
VIII. ALL OF THE FOLLOWING TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED <i>(No LAB required for newborns)</i>				
1. HEMATOLOGY <i>(age 1 and over)</i> Hematocrit _____ %	3. BLOOD LEAD LEVEL <i>(recommended for ages 9 mo. up to 6 years)</i> _____	5. TUBERCULIN TEST (5TU PPD) <i>(recommended for all ages 1 and over, including those with previous BCG)</i> 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 <i>(or if previously not done)</i> a. Blood Type ABO _____ (Rh) D _____ (weak) D ^J _____ b. G6PD Normal _____ Deficient _____	
2. URINALYSIS <i>(preemployment age 1 and over, separation and when indicated).</i> Specific Gravity _____ Albumin _____ Sugar _____ WBC _____ RBC _____ Casts _____ Other _____	4. CHEST X-RAY <i>(for new TB skin test convertors, or when indicated).</i> _____ Date (mm-dd-yyyy) _____ Results:			

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.

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.