





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 <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 _____
-------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------

6. SOCIAL SECURITY NUMBER (Employee/Applicant/Sponsor)	5b. TYPE OF EMPLOYMENT <input type="checkbox"/> Foreign Service <input type="checkbox"/> Contractor <input type="checkbox"/> Civil Service Excursion Tour
--------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------

7. PLACE OF BIRTH City _____ Country _____	8. POST OF ASSIGNMENT AND DATES OF DEPARTURE/ARRIVAL
-----------------------------------------------	------------------------------------------------------

9. MAILING ADDRESS (Medical Clearance Abstract will be mailed to listed address) _____ _____ _____	a. Proposed Post _____ EDA _____ b. Present Post _____ EDD _____ c. Last 3 Posts _____ _____
----------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------

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:

II. HAVE YOU EVER HAD:		NAME OF EXAMINEE:			
YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Frequent or severe headaches?	23. Joint or bone deformity or fracture?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Dizzy spells, fainting, or blackouts?	24. Malaria or other tropical disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Epilepsy or seizures?	25. Any skin problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Eye trouble or vision problems?	26. Growth pattern abnormality?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Any neurological disorder?	27. Tuberculosis or exposure to tuberculosis?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Tooth or gum problems?	28. A blood transfusion?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Difficulty with your hearing?	29. Anemia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Other ear, nose, or throat problems?	30. Frequent crying spells?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Hayfever or other allergies?	31. Sadness or withdrawal?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Asthma, wheezing or chronic cough?	32. Trouble sleeping?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Trouble catching your breath?	33. Fears or worries?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Heart murmur or heart problems?	34. Difficulty in relaxing or calming down?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Rheumatic fever?	35. Change in academic functioning?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Stomach, liver, or intestinal problems?	36. Low academic functioning?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Jaundice or hepatitis?	37. Difficulty with attention or focusing?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Bedwetting after age 3?	38. Learning disability or disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Bowel or bladder daytime accidents?	39. If #38 is yes, past or current Individualized Education Plan (IEP)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Kidney trouble; stone, blood in urine?	40. Speech delay or other speech problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Bladder infections?	41. Behavioral or discipline problem at home or school?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Sugar or protein in urine?	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?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Diabetes?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Arthritis or joint pains?	

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? Parents 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).

<b>VI. TO BE COMPLETED BY THE EXAMINER</b>		<b>NAME OF EXAMINEE:</b>		
<b>1. RACE</b> (check one) (need for genetic risk factors) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other (specify) _____	<b>2. HEIGHT</b> _____ in. or _____ cm. _____ percentile	<b>3. WEIGHT</b> _____ lb. or _____ kg. _____ percentile	<b>4. PULSE</b> (must be recorded)	<b>5. BLOOD PRESSURE</b> (age 5 and Over)
<b>6. DISTANT VISION</b> (age 5 and Over) Right 20/ _____ Corrected 20/ _____ Left 20/ _____ Corrected 20/ _____		<b>7. HEAD CIRCUMFERENCE</b> (18 months and under) _____ in. or _____ cm.	<b>8. DEVELOPMENT APPROPRIATE FOR AGE</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Attach developmental screen if indicated under age 4	
		<b>9. IMMUNIZATIONS REVIEWED</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Immunizations current? Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>VII. CLINICAL EVALUATION</b> Check each item as indicated. Enter "NE" if not evaluated.	Normal	Abnormal	<b>NOTES</b> (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

<b>VIII. ALL OF THE FOLLOWING TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED</b> (No LAB required for newborns)			
<b>1. HEMATOLOGY</b> (age 1 and over)  Hematocrit _____ %	<b>3. BLOOD LEAD LEVEL</b> (recommended for ages 9 mo. up to 6 years) _____	<b>5. TUBERCULIN TEST (5TU PPD)</b> (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: _____	<b>6. PREEMPLOYMENT ONLY</b> (or if previously not done)  a. Blood Type ABO _____ (Rh) D _____ (weak) D <sup>J</sup> _____  b. G6PD Normal _____ Deficient _____
<b>2. URI ANALYSIS</b> (preemployment age 1 and over, separation and  Specific Gravity _____ Albumin _____ Sugar _____ WBC _____ RBC _____ Casts _____ Other _____	<b>4. CHEST X-RAY</b> (for new TB skin test converters, or when indicated).  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.**