Initial Medical Exam
Unaccompanied Children's Program
Office of Refugee Resettlement (ORR)

General Information (to be completed by program staff)

Child	Last name:	First name:		
	DOB:	A#:	Gender:	
Healthcare Provider	Name: **MD / DO / PA / NP**	Phone number:	Clinic or Practice:	
	Street address:	City or Town:	State:	Date of visit:
Program	Name of program staff with child:	Program name:		

History and Physical (to be completed by healthcare provider)

Vital Signs

T (C°):	HR:	BP (≥ 3 years):	RR:	Ht (cm):	Wt (kg):

Allergies € Check if none

€ Food, specify: € Medication, specify: € Other, specify:

Vision (≥ 5 years)

	Right Eye	Left Eye	Both eyes
Corrected	20 /	20 /	20 /
Uncorrected	20 /	20 /	20 /

Medical History

Concerns expressed by child or caregiver: € No concerns

Past medical history (include surgeries and hospital admissions):

Family History:

Travel history (countries visited, dates of arrival and departure for each):

Reproductive History: LMP: ____ / ____ / _____ or € N/A Previous pregnancy: G _____ P _____ or € N/A

Review of Systems (ROS)

Check all applicable signs and symptoms and enter the date each began:

€ No abnormal findings		€ Pain, location: _____	___/____/____
€ Fever (>37.8 C°) or chills	___/____/____	€ Red eyes	___/____/____
€ Runny nose	___/____/____	€ Sore throat	___/____/____
€ Cough	___/____/____	€ Difficulty breathing / Shortness of breath / Wheezing	___/____/____
€ Nausea	___/____/____	€ Vomiting	___/____/____
€ Diarrhea	___/____/____	€ Neck stiffness	___/____/____
€ Headache	___/____/____	€ Confusion/Altered mental status	___/____/____
€ Dizziness	___/____/____	€ Neurologic symptoms	___/____/____
€ Skin lesions or rash	___/____/____	€ Yellow skin or eyes	___/____/____
€ Swollen glands	___/____/____	€ Unusual bleeding	___/____/____
€ Other 1, specify:			___/____/____
€ Other 2, specify:			___/____/____

Physical Examination

Check each system to indicate if normal or abnormal and describe. Leave blank if not evaluated**:**

System	Normal	Abnormal	Describe
General appearance	€	€	
HEENT	€	€	
Neck	€	€	
Heart	€	€	
Lungs	€	€	
GU/GYN	€	€	
Extremities	€	€	
Abdomen	€	€	
Back/Spine	€	€	
Neurologic	€	€	
Skin (include tattoos)	€	€	
Other: _____	€	€	

Psychosocial Risk

In each section, place a check next to each reported condition/history/behavior & describe where applicable:

Mental Health (Over the past 3 months) € Check if no concerns

€ Feels empty, hopeless, sad, numb more often than not
€ Feels constantly worried, anxious, nervous more often than not
€ Experiences mood swings, from very high to very low
€ Relives traumatic events from the past
€ Feels easily annoyed or irritated
€ Feels afraid, easily startled, jumpy
€ Has trouble concentrating, restless, too many thoughts
€ Has trouble eating, sleeping
€ Feels helpless
€ Feels like hurting others
€ Feels like hurting self, would be better off dead
€ Other concerns:

Physical Abuse History € Check if physical abuse is denied

€ Victim of physical abuse, specify who/when/where: _____
_____
_____
€ In home country € During journey to U.S.
€ In US, not in ORR custody € In ORR custody

Sexual Activity/Abuse History € Check if sexual activity or abuse are denied

€ Consensual sexual activity (oral/vaginal/anal)
€ Sexual abuse, specify who/when/where: _____
_____
_____
€ In home country € During journey to U.S.
€ In US, not in ORR custody € In ORR custody
€ Previous STD diagnosis, specify: _____

Substance Use € Check if substance use is denied

€ IVDU: € Alcohol: € Tobacco: € Other:

Laboratory Testing

Ordered	Test	Indicators	Result		
			Positive	Negative	Indeterminate
€	Flu, rapid	Fever + cough or sore throat	€	€	€
€	HIV	≥13 yrs or Sexual activity/abuse	€	€	€
€	Pregnancy	≥10 yrs or Sexual activity/abuse	€	€	€
€	Lead **(positive ≥5 mcg/dl)**	6 mos up to 6 yrs	€	€	€
€	Hepatitis B surface antigen	Sexual activity/IVDU	€	€	€
€	Hepatitis C antibody	IVDU	€	€	€
€	Syphilis RPR/VRDL	Sexual activity/abuse	€	€	€
€	Chlamydia NAAT	Sexual activity/abuse	€	€	€
€	Gonorrhea NAAT	Sexual activity/abuse	€	€	€

TB Screening (Use Supplemental TB Screening form for result documentation)

Has child ever been a close contact to someone with ***active*** TB disease? € No € Yes, specify:
Has child ever been treated for ***active*** TB disease? € No € Yes, specify:
Has child ever been treated for ***latent*** TB infection? € No € Yes, specify:

TB screening method ordered: € TST € IGRA € CXR € Was or will be tested elsewhere

Assessment and Plan

Assessment: Child without complaints, symptoms, diagnoses/conditions; no meds (including OTC) or referrals needed: € No € Yes
If No, check all diagnoses that apply. If "Other" is selected, specify in the space provided.

General/Constitutional
- € Allergy (e.g., drug reaction, food allergy), specify: _____
- € Dehydration € Malnourished
- € Other: _____

HEENT
- € Headache/Migraine € Hearing issues
- € Otitis media/Ear infection € Pharyngitis (Not strep throat)
- € Rhinitis € Strep throat
- € Vision issues • Viral/Bacterial Conjunctivitis
- € Other: _____

Respiratory/Pulmonary
- € Asthma € Influenza-like illness (ILI)
- € Influenza, lab-confirmed; specify: _____
- € Upper/lower respiratory illness; specify: _____
- € Other: _____

Cardiovascular
- € Heart murmur € Syncope/fainting
- € Other: _____

Gastrointestinal
- € Abdominal pain € Gastroenteritis
- € Heartburn/reflux € Intestinal parasites
- € Other: _____

Genito-urinary/Reproductive
- € Childbirth € Pregnancy/Pregnancy-related
- € Genital warts € Urinary tract infection
- € Other: _____

Neurological
- € Developmental delay € Seizure/epilepsy
- € Other: _____

Musculoskeletal
- € Back pain € Fracture
- € Leg pain € Sprain/Strain
- € Other: _____

Skin, Hair, and Nails
- € Cellulitis € Dermatitis/Rash (not acne)
- € Ingrown toenail € Lice
- € Scabies € Tinea pedis
- € Other: _____

Potentially Reportable Infectious Disease
- € Acute hepatitis A € Acute/chronic hepatitis B
- € Acute/chronic hepatitis C € Chikungunya
- € Chlamydia € COVID-19
- € Dengue € Gonorrhea
- € HIV € Malaria
- € Measles € Mumps
- € Pertussis € Rubella
- € Sepsis/Meningitis € Syphilis
- € TB € Typhoid fever
- € Varicella € Zika virus
- € Viral hemorrhagic fever, specify: _____
- € Other: _____

Abuse
- € Sexual € Physical
- € Other: _____

€ Other, Medical:
_____
_____
_____

Behavioral and Mental Health Concerns
- € ADHD/ADD € Adjustment disorder
- € Anxiety disorder € Bipolar disorder
- € Borderline personality disorder € Depressive disorder
- € Panic disorder € PTSD
- € Schizophrenia € Self-injury/cutting
- € Suicide ideation/attempt
- €
- € Other: _____
_____

Plan: Check all that apply and specify in the space provided.

Return to clinic:
€ PRN/As needed € Follow-up (specify condition, timing): _____

€ Referred to specialist/counselor: _____

€ Prolonged treatment/therapy (e.g., physical therapy): _____

€ New/Current medications (specify name, reason, date started, dose, and directions and indicate if psychotropic):
_____
_____

€ Immunizations given/validated from foreign record

€ List immunizations not given due to medical contraindication: _____

€ Age-appropriate anticipatory guidance discussed and/or handout given

€ Child quarantined/isolated at the program for a diagnosis, specify: _____

€ Release of child delayed from the program because of a diagnosis, specify: _____

€ Other: _____
_____

Additional Information

Potentially Reportable Infectious Diseases			
Specify the reportable infectious disease diagnosed:			
Lab testing performed to confirm the diagnosis:	• No	• Yes	
Health department notified by program:	• No	• Yes	• Not applicable
Intakes delayed/postponed because of this diagnosis:	• No	• Yes	
UAC exposed to this child while infectious:	• No	• Yes	(Complete a Contact Investigation Form for each exposed UAC)
Number of staff members exposed to this diagnosis:			

Potentially Reportable Infectious Disease (Non-TB) Lab Testing				
Disease Tested	**Collection Date**	**Specimen Type (e.g., Serum)**	**Test Type (e.g., IgM)**	**Result**

Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

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