Report of Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 02/28/2019

► **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon)

1. **Your Full Name**

Family Name (Last Name) | Given Name (First Name) | Middle Name

2. **Physical Address**

Street Number and Name | Apt. Ste. Flr. ☐ ☐ ☐ Number

City or Town | State | ZIP Code

3. **Other Information**

A. Sex ☐ Male ☐ Female

B. Date of Birth (mm/dd/yyyy)

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
► **A-**

F. USCIS Online Account Number (if any)
►

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

3. Applicant's Mobile Telephone Number (if any)

4. Applicant's Email Address (if any)

G & G Medical Group Consent to Receive Vaccines\Disclosure Note

Please circle yes or no to the question below. If any questions are unclear, please ask for help.

Allergies: No_____ Yes_____ Medications: Penicillin____ Sulfa____ Aspirin____ Others_____

1. Do you have a fever, diarrhea, or vomiting today?	**Yes**	**or**	**No**
2. Are you allergic to eggs, Baker's yeast, preservatives (i.e. sulfites), thimerosal, streptomycin, neomycin, Arginine, gelatin or **latex?**	**Yes**	**or**	**No**
3. Have you ever had a severe reaction to any vaccine which required medical care?	**Yes**	**or**	**No**
4. Are you or anyone in your home, or anyone you take care of being treated or any immune deficiency disorder?	**Yes**	**or**	**No**
5. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, or blood disorders?	**Yes**	**or**	**No**
6. Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	**Yes**	**or**	**No**
7. Have you had Guillain-Barre Syndrome, a condition which causes paralysis?	**Yes**	**or**	**No**
8. Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc)?	**Yes**	**or**	**No**
9. Are you on immunosuppressive therapy, including high-dose corticosteroids?	**Yes**	**or**	**No**
10. Have you received any vaccines in the past 4 weeks?	**Yes**	**or**	**No**
11. For women: Are you pregnant or planning pregnancy in the next month?	**Yes**	**or**	**No**

Date: _____ **Initials:** _____

I have read, or have had read to me, the provided Vaccine Information Statement(s) ("VIS").I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize this information to be forwarded to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the company that is administering the vaccine(s); G&G Medical Group the subsidiaries and affiliates of G&G Medical Group the respective directors, officers, employees, and agents of G&G Medical Group and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

PLEASE SIGN THAT YOU'RE ECEIVED OUR HIPAA NOTICE OF PRIVACY PRACTICES

Disclosure note:

G & G Medical Group will only certify form I-693 only after all supporting documentation have been received and reviewed by our civil surgeons. We don't complete or certify any other Immigration forms regarding disability, waivers etc.

Immigration exams are NOT covered by INSURANCE and are considered SELF PAY service. We will not submit any claims to insurance for payment.

_____ _____ _____

Patient Signature **Print Name** **Date**

_____ _____

Guardian **Date**

Chronic Medical Conditions - Please circle Yes or No

Diabetes	**Yes**	**or**	**No**
Thyroid disease	**Yes**	**or**	**No**
High blood pressure	**Yes**	**or**	**No**
High cholesterol	**Yes**	**or**	**No**
Cancer	**Yes**	**or**	**No**
Asthma	**Yes**	**or**	**No**
Mental illness	**Yes**	**or**	**No**
Other _____	**Yes**	**or**	**No**

Current Medications: Yes \ No

Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**