

Applicant Name _____

Medical Report



To be completed by your Doctor - Relatives may not complete this report

As an Au Pair in America, the applicant will be living for an extended period of time in the home of a family with young children. It is therefore important that we are advised of any physical, mental or emotional health problems or family history issues which may have an impact on the applicant's ability to carry out their duties appropriately. Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program.

Do you have access to the patient's full medical history? Yes No **How long have you known the patient?** _____

What date was the patient's last medical appointment? _____ **or please circle** Unknown

What was the reason? (please tick) Annual visit Minor medical concern/illness Chronic condition
 Other (please describe) _____

Tick the appropriate box if there are any abnormalities to the following systems:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Ears, nose and throat | <input type="checkbox"/> Eyes | <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Respiratory system/lungs |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Skin | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Brain, nervous system | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Metabolic | <input type="checkbox"/> Other |

If you have ticked any of the above, please provide details including dates, treatment and medication required:

Is the applicant, to the best of your knowledge a likely carrier of any infectious disease, such as Hepatitis B or C, or the HIV virus?
(The applicant does not need to be tested) Yes No

Have you noticed any changes in weight or eating habits of the applicant that may indicate an eating disorder? Yes No

Has the applicant ever been hospitalised or had surgery, including cosmetic surgery? Yes No

Is the applicant currently or has the applicant ever been treated/counselled or received medication for a nervous condition, eating disorder, depression or emotional problem? Yes No

Have you any knowledge that the applicant has ever been a victim of physical, emotional or sexual abuse? Yes No

Is there any history of nervous or emotional problems, depression or abuse (sexual, emotional or physical) in the applicant's family background? Yes No

If you have answered 'yes' to any of the above, please provide details including dates, treatment and medication required:

Please use this space to comment on the applicant's current emotional wellbeing and provide any other relevant information:

After having reviewed the applicant's medical notes, please give your opinion on the applicant's general state of health

- Excellent Good Fair Poor

Name of Doctor _____
 Address _____

 Telephone _____

Please add your Doctor's or Medical Practice stamp below

I have examined and/or reviewed medical notes of (Tick if applicable) the above named applicant and I find them to be capable of benefitting from and fully participating in an Au Pair in America program.

Do you speak English? Yes No **If no, did you fully understand all the questions asked on this form?** Yes No

Doctor's Signature: _____ **Date:** _____

Applicant Name _____

Vaccination Record



To be completed by your Doctor - Relatives may not complete this report

It is an Au Pair in America program requirement for the applicant to be immunized against certain diseases. Please provide the vaccination history for this applicant below.

Please confirm the applicant is immunized against the following:

- Tetanus Yes Date _____
- Measles Yes Date _____
- Mumps Yes Date _____
- Rubella (German Measles) Yes Date _____

Tuberculosis

- This is mandatory for applicants from Brazil, China, South Africa, Russia and Thailand.
- Highly recommended for applicants from other countries.

- BCG immunization **OR** Yes Date _____ No
- Mantoux test **OR** Yes Date _____ No **Result:** Positive Negative
- Chest X Ray Yes Date _____ No **Result:** Clear Not clear

Please note: positive test results (unless the applicant was immunized against TB) will require a copy of a recent chest x-ray

The following immunizations are highly recommended but not required:

- Flu vaccine Yes Date _____ No
- Small Pox Yes Date _____ No
- Typhoid Yes Date _____ No
- Hepatitis B Yes Date _____ No
- Diphtheria Yes Date _____ No
- Polio Yes Date _____ No
- Meningitis Yes Date _____ No
- Chickenpox – if not previously suffered from Yes Date _____ No

Whooping Cough

If the applicant is placed with a Host Family that requires the care of a baby under the age of 6 months, the applicant will be required to be immunized against Whooping Cough. Please confirm if the applicant is immunized:

- Whooping Cough Yes Date _____ No

Name of Doctor _____ Address _____ _____ Telephone _____ _____	Please add your Doctor's or Medical Practice stamp below
--	--

Do you speak English? Yes No If no, did you fully understand all the questions asked on this form? Yes No

Doctor's Signature: _____ Date: _____