Membership no:

Medical Form

INSTRUCTIONS

PART A To be completed by the Applicant and reviewed by the Doctor
PART B To be completed by the Doctor

1 Please complete this form as soon as possible
2 Take Part A and Part B to your Doctor for review and completion
3 Upload Part A and Part B to the Participant site
4 Please note that the doctor completing this form cannot be a family member

PART A – To be completed by the Applicant and reviewed by the Doctor

Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program

Full Name:

Address:

☐ Female ☐ Male

Date of Birth: _ _ / _ _ / _ _ _ _ Age:

Height:

Weight:

Next of kin – please provide details of the relative or person we can contact in case of **emergency** when you are in the US

Full Name:

Relationship to you:

Telephone no:

Best time to call:

Address:

Tick the appropriate box if you presently suffer from or have ever had/experienced:

- ☐ Acne / Skin problems
- ☐ Anemia
- ☐ Anxiety/Nervous condition
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores (Herpes 1)
- ☐ Counselling/Psychotherapy
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Ear infection
- ☐ Eating disorder
- ☐ Emotional abuse
- ☐ Epilepsy/Convulsions
- ☐ Eye problems
- ☐ Gall bladder problems
- ☐ Gastritis
- ☐ Genital Herpes
- ☐ Genitourinary problems
- ☐ Glandular fever
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ High / Low Blood pressure
- ☐ HIV
- ☐ Kidney disease
- ☐ Learning disabilities
- ☐ Malaria
- ☐ Measles
- ☐ Menstrual problems
- ☐ Migraines/Headaches
- ☐ Mumps
- ☐ Orthopaedic problems
- ☐ Physical abuse
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rubella (German measles)
- ☐ Scarlet fever
- ☐ Self harming
- ☐ Sexual abuse
- ☐ Sleep walking
- ☐ Suicide attempt
- ☐ Thyroid condition
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Other (please specify)

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

Membership no:

Medical Form

Have you ever received counselling or sought advice from a psychologist, psychiatrist, counsellor and/or doctor? ☐ Yes ☐ No

Is your physical ability restricted in any way? ☐ Yes ☐ No

Do you take any medications or prescription drugs? If yes, state how often and for which condition below? ☐ Yes ☐ No

Have you ever been treated for alcoholism/drug dependency? ☐ Yes ☐ No

Are you currently taking any medication (including contraceptive pill)? ☐ Yes ☐ No

Is there any history of nervous or emotional problems, depression or abuse (sexual, emotional or physical) in your family background? ☐ Yes ☐ No

Are you on any medical treatment that will require medical attention during your time as an au pair? ☐ Yes ☐ No

Do you wear braces? ☐ Yes ☐ No

Do you have any limitations that restricts you from lifting a child (i.e. recent surgery/back problems etc)? ☐ Yes ☐ No

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

Do you smoke? ☐ Yes ☐ No

If yes, how many cigarettes do you smoke a day? _____

Tick the appropriate box if you suffer from any allergies:

☐ Insect stings ☐ Hay fever ☐ Animals ☐ Food ☐ Smoke ☐ Penicillin ☐ Other drugs ☐ Other

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

Other than to have your Medical Form completed by your doctor, when was the last time you visited the doctor and why, including dates, treatments and medication required:

Au Pair IN AMERICA

Membership no:

Medical Form

**** Please note the following questions and answers will not be shared with host families ****

Were you ever or have you had a Pregnancy/Miscarriage/Termination? ☐ Yes ☐ No

If you have answered 'yes' please provide details including dates, treatments and medication required:

Have you ever suffered from a venereal disease/STI? ☐ Yes ☐ No

If you have answered 'yes' please provide details including dates, treatments and medication required:

****

I understand and agree that American host families may have access to this Medical Form and I give permission to the Doctor completing Part B to review all my responses in Part A of this form and to provide or discuss additional medical information, if requested to do so by Au Pair in America.
Should an emergency situation arise, I authorize any medical provider to release information regarding my condition to Au Pair in America or their insurance provider/emergency assistance services and understand that they can contact my next of kin without my prior consent.
The above information is correct to the best of my knowledge and I hereby give permission for emergency medical care to take place should it be necessary. I also understand that withholding or falsifying any information may result in me being withdrawn from the program.
I understand that insurance provided through Au Pair in America, including any upgrades, is not designed to cover any pre-existing or congenital conditions. A pre-existing condition is an illness or injury that I show symptoms of or received treatment for within 1 year before my departure to the United States (the condition does not need to be officially diagnosed to be considered pre-existing). A congenital condition is an illness that I was born with. Should I participate in the Au Pair in America program and need medical care for a pre-existing or congenital condition or an event arising from a pre-existing or congenital condition. I understand that all medical expenses will be my responsibility to pay and as such will arrange any necessary insurance where required. If required I will upload a copy of my insurance documents to my Participant site upon placement. I understand that dental treatment is not covered by the Au Pair in America insurance policy and I will see a dentist before I leave for the US.

Signature: ______________________________ **Date:** _ _/_ _/_ _ _ _

Note: This form must be completed and signed by the applicant. Remember to keep a copy of your fully completed Medical Form and take it with you to the US.

Membership no:

Medical Form

PART B – To be completed by the Doctor

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. Is it therefore important that we are advised of any physical, mental or emotional health problems or family history issues which may have a bearing 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.

Applicant's Full Name:

Are you related to the applicant? ☐ Yes ☐ No *Please note relatives may not complete this form.*

Have you reviewed the 3 pages of information in Part A of this Medical Form that was completed by the applicant? ☐ Yes ☐ No

Do you have access to the patient's full medical history? ☐ Yes ☐ No

How long have you known the applicant? _____

It is a program requirement for the applicant to be immunized against the following:

Tetanus	☐ Yes	Date_____
Measles	☐ Yes	Date_____
Mumps	☐ Yes	Date_____
Rubella (German Measles)	☐ Yes	Date_____

Tuberculosis immunization **OR**	☐ Yes	Date_____	☐ No
Tuberculosis test **OR**	☐ Yes	Date_____	☐ No **Result:** ☐ Positive ☐ Negative
Chest X Ray	☐ Yes	Date_____	☐ No **Result:** ☐ Clear ☐ Non-clear

Please note: positive test results (unless 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
Whooping Cough	☐ Yes	Date_____	☐ No
Meningitis	☐ Yes	Date_____	☐ No
Chicken Pox – if not previously suffered from	☐ Yes	Date_____	☐ No

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

☐ Ears, nose and throat	☐ Eyes	☐ Neuropsychiatric	☐ Respiratory system/lungs
☐ Genitourinary	☐ Skin	☐ Cardiovascular	☐ Musculoskeletal
☐ Brain, nervous system	☐ Gastrointestinal	☐ Metabolic	☐ Other _____

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

_____

_____

_____

Membership no:

Medical Form

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 for the applicant that may give rise to concern regarding an eating disorder? ☐ Yes ☐ No

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

Has the applicant ever been hospitalized or had surgery? ☐ 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 No _____

Please add your Doctor's or Medical Practice stamp above

I have examined ☐ and/or reviewed medical notes of ☐ (Tick if applicable) the above named applicant and I find him/her 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 the form? ☐ Yes ☐ No

Signature _____ Date _____