Au Pair IN AMERICA

Medical Form

Membership no 2005

If known

INSTRUCTIONS

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

1. Please complete this form immediately.
2. Make a copy of your completed form. **Keep one copy (original or photocopy) to take with you to the United States.**
3. Post or fax the other copy to the London office immediately or give it to your interviewer to forward.
4. Please note the Doctor completing this form may not be a family member.

PART A – to be completed by Applicant & reviewed by Doctor

Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program

NAME OF APPLICANT – AS IT APPEARS IN PASSPORT

Last Name First Name Other Initials

Full Postal Address

Postcode Country Home Telephone No

Date of birth *day* *month* *year* Age Sex Female Male

Height: feet/inches or metres Weight: pounds or kilos

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

Name Relationship to Applicant

Full Postal Address

Postcode Country

Telephone No *(day)* *(evening)*

Are you covered by additional insurance beyond that provided by the Au Pair in America program? ☐ Yes ☐ No

If yes, give details and attach a photocopy of the policy documents (write your name clearly on each page)

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

☐ Tuberculosis	☐ Chicken pox	☐ Malaria	☐ Pregnancy/Miscarriage or Termination	☐ Glandular fever
☐ Anaemia	☐ Diabetes	☐ Heart disease	☐ Ear infection	☐ Kidney disease
☐ Eye problems	☐ Herpes (cold sores)	☐ Menstrual problems	☐ German measles (rubella)	☐ Sleep walking
☐ Arthritis	☐ Scarlet fever	☐ Rheumatic fever	☐ Gall bladder problems	☐ Migraines/Headaches
☐ Ulcers	☐ Depression	☐ Epilepsy/Convulsions	☐ Bulimia	☐ Anorexia
☐ Dizziness/Fainting	☐ Polio	☐ Mumps	☐ Varicose veins	Hepatitis ☐ A ☐ B ☐ C
☐ Venereal disease	☐ Hernia	☐ Asthma	☐ Suicide attempt	

☐ Other (please specify)

If you have ticked any of the above, give details including dates as applicable

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Last Name First Name Other Initials

Other than to complete this medical form, when was the last time you visited a Doctor and why? ______

Have you ever received counseling and/or medication for a nervous condition, eating disorder, depression or emotional problem?

☐ Yes ☐ No If yes, give details and dates ______

Have you ever been a victim of sexual, emotional or physical abuse? ☐ Yes ☐ No If yes, give details and dates ______

Is there any history of nervous or emotional problems, depression or abuse (sexual, emotional or physical) in your family background?

☐ Yes ☐ No If yes, give details and dates ______

Tick the appropriate box if you suffer from any allergies:

☐ Penicillin ☐ Other drugs ☐ Insect sting ☐ Hay fever ☐ Foodstuffs ☐ Other

If you have ticked any of the above, give full details ______

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

Do you have any habits which may affect your health (e.g. alcohol, cigarettes, drugs)? ☐ Yes ☐ No

Do you have any chronic or recurring illnesses? ☐ Yes ☐ No

Are you currently taking any medication? (including oral contraceptives) ☐ Yes ☐ No

Do you carry any infectious diseases such as Hepatitis B or the HIV virus in your blood? ☐ Yes ☐ No

If you have ticked any of the above, give full details including names of any medication ______

In view of the nature of the program for which you have applied, it is the practice of Au Pair in America and EduCare in America to request a criminal record check.

Have you ever been convicted of a criminal offence, or are you at present the subject of criminal charges? ☐ Yes ☐ No

If yes, give full details ______

I understand and agree that American host families may have access to this Medical Form and 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.

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.

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☐☐☐☐☐☐☐

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NAME OF APPLICANT – AS IT APPEARS IN PASSPORT

Last Name First Name Other Initials

PART B – to be completed by Doctor

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

As an au pair or companion 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 a bearing on the applicant's ability to carry out his/her duties appropriately. Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program.

Please review the information provided in **PART A** and give your opinion of the applicant's general state of health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please ensure that the applicant is currently immunized/tested against the following:

Tetanus ☐ Yes Date ______________ Measles ☐ Yes Date ______________

Mumps ☐ Yes Date ______________ German measles (rubella) ☐ Yes Date ______________

Has the applicant been immunized against tuberculosis (TB)? ☐ Yes ☐ No Immunization Date ______________

If no, please provide details of a tuberculin test or attach the results of a recent chest x-ray. Test date ______________ Result: ☐ Negative ☐ Positive

(Please note: positive test results will require additional information on dates the applicant had TB, details of any treatment and a copy of a recent chest x-ray.)

Please also indicate whether the applicant has been immunized against the following:

Typhoid ☐ Yes ☐ No Date ______________ Diphtheria ☐ Yes ☐ No Date ______________

Polio ☐ Yes ☐ No Date ______________ Whooping cough ☐ Yes ☐ No Date ______________

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

☐ Ears, nose and throat ☐ Eyes ☐ Neuropsychiatric ☐ Respiratory system/lungs ☐ Genitourinary

☐ Skin ☐ Cardiovascular ☐ Musculoskeletal ☐ Brain, nervous system ☐ Gastrointestinal

☐ Metabolic ☐ Other ______________

If you have ticked any of the above, please give details and dates ______________

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 If yes, give details ______________

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 If yes, give details and dates ______________

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 If yes, give details and dates and comment on the applicant's present emotional well being

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Has the applicant been hospitalized for more than three days? ☐ Yes ☐ No If yes, give details and dates

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

If yes, please comment

Does the applicant have any history of physical, emotional or sexually related problems that you might wish an American family to know as they consider whether the applicant is a suitable person to live in their home and care for their small children for a year? ☐ Yes ☐ No

If yes, please comment

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 yes, please give details and dates

Has the applicant, to the best of your knowledge, ever had any criminal convictions or charges filed against them? ☐ Yes ☐ No

If yes, please give full details

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

How long have you known the applicant?

Please use this space to give any additional relevant information

Name of Doctor

Address

Telephone No

I have examined ☐ and/or reviewed medical notes of ☐ *(tick as 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.

Please add your Doctor's or medical practice stamp here.

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

Signature **Date**