Applicant Name _____

_____

Medical Report

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

Au Pair IN AMERICA

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 Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program.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? _____/ Unknown **What was the reason? (please tick below)**

☐ Annual visit ☐ Minor medical concern/illness ☐ Chronic condition ☐ Other (please describe) _____

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 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

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

Au Pair IN AMERICA

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, Kenya, Mozambique, Nigeria, South Africa, Russia, Thailand, Uganda, Zimbabwe. It is 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 (DPT/DTaP/Tdap)	☐ Yes	Date _____	☐ No

Covid-19

Has the applicant been vaccinated against Covid-19?

☐ Yes - first dose Date _____ ☐ Yes - second dose Date _____ ☐ No

Please specify which vaccination they received: _____

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:** _____