



# PHYSICIAN'S REPORT

The applicant below has applied to become an au pair in the United States for one year. As a part of acceptance into the program, an established physician must attest to the health of the applicant. The physician must be the "family physician" or a physician in a clinic in which the applicant has received care for a minimum of 5 years.

Since the applicant will be spending time with young children, it is important that **Agent Au Pair** be advised of any medical conditions, listed or otherwise, that would impair his/her ability to perform in this capacity in a satisfactory manner. Please answer all questions to the best of your knowledge.

Name of applicant \_\_\_\_\_ Date of birth \_\_\_\_\_

City \_\_\_\_\_ Postal code and Country \_\_\_\_\_

Name of Doctor and/or Clinic \_\_\_\_\_

Address of Doctor and/or Clinic \_\_\_\_\_

Telephone \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

Has the applicant been under the care of this medical office for at least 5 years?  Yes  No

Date of exam \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Type \_\_\_\_\_

Vision without glasses \_\_\_\_\_ Does the applicant wear glasses? \_\_\_\_\_ Vision with glasses \_\_\_\_\_

In your opinion, what is the applicant's general state of health?  Excellent  Good  Fair  Poor

## 1. Has the applicant ever had (or currently have):

	Yes	No		Yes	No
allergies	<input type="checkbox"/>	<input type="checkbox"/>	anaemia	<input type="checkbox"/>	<input type="checkbox"/>
anorexia	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>	bulimia	<input type="checkbox"/>	<input type="checkbox"/>
chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	malaria	<input type="checkbox"/>	<input type="checkbox"/>
measles	<input type="checkbox"/>	<input type="checkbox"/>	mumps	<input type="checkbox"/>	<input type="checkbox"/>
tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	ulcers	<input type="checkbox"/>	<input type="checkbox"/>
hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>
seizures	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>

other \_\_\_\_\_

If the answer is yes to any of the above questions, please give details and dates \_\_\_\_\_

## 2. Surgery and Medication

Has the applicant undergone surgery of any kind?  Yes  No

If yes, give dates and details (use a separate sheet of paper if necessary)

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Is the applicant currently taking any medications (other than birth control)?  Yes  No

If yes, list \_\_\_\_\_

**3. Has the applicant ever received treatment for any of the following:**

psychological problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	depression or emotional disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
anxiety disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	is the applicant restricted physically or mentally?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
schizophrenia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	does the applicant have a learning disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
eating disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**4. Vaccinations:**

Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Diphtheria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
German Measles (Rubella)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____
Typhoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date _____

**5. Are there any abnormalities of the following systems?**

Tonsils, nose, throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	neurological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye, vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	muscular skeletal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ears, hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
metabolic	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, give details \_\_\_\_\_

**6. Has the applicant taken a tuberculosis test?**  Yes  No Date \_\_\_\_\_

If yes, what was the result? (tick one)  Test positive for TB  Does not have TB

**7. Other comments**

Is there any condition to your knowledge that Agent Au Pair may want to consider before placing the applicant in an American home with small children for one year? If yes, explain \_\_\_\_\_

Additional comments of physician (attach a separate sheet of paper if necessary):

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**I certify that the above information is complete and accurate and all important medical information has been included.**

Physician's Signature/Stamp \_\_\_\_\_ Date \_\_\_\_\_