



<i>For office use only</i>	
Reference: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of App Received <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**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 or town of residence \_\_\_\_\_ 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

**Has the applicant ever had (or currently have):**

	Yes	No		Yes	No
allergies	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<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"/>
emotional disorders	<input type="checkbox"/>	<input type="checkbox"/>	other _____		

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

Has the applicant undergone surgery of any kind? \_\_\_\_\_

If yes, give dates and details \_\_\_\_\_

Has the applicant ever received treatment for psychological problems?  Yes  No

Is the applicant restricted physically or mentally?  Yes  No

Is the applicant currently taking any medications?  Yes  No

Does the applicant have a learning disability?  Yes  No

Has the applicant ever had an anxiety disorder?  Yes  No

Has the applicant ever been treated for schizophrenia?  Yes  No

**Has the applicant received the following immunizations?**

polio  Yes  No Date \_\_\_\_\_

diphtheria  Yes  No Date \_\_\_\_\_

measles  Yes  No Date \_\_\_\_\_

German measles (rubella)  Yes  No Date \_\_\_\_\_

Tetanus  Yes  No Date \_\_\_\_\_

Typhoid  Yes  No Date \_\_\_\_\_

tuberculosis test  Yes  No Date \_\_\_\_\_

whooping cough  Yes  No Date \_\_\_\_\_

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

head, ears, nose, throat  Yes  No

skin  Yes  No

cardiovascular  Yes  No

gastrointestinal  Yes  No

metabolic  Yes  No

muscuskeletal  Yes  No

neurological  Yes  No

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

To your knowledge has the applicant been treated for depression or emotional disorders?  Yes  No

If yes, explain \_\_\_\_\_

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 \_\_\_\_\_

Other comments of physician: \_\_\_\_\_

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

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

Agent Au Pair Interviewer's Use only		
VERIFIED BY _____	DATE: _____	SIGNATURE: _____