



goAUPAIR®
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PHYSICIAN'S REPORT FORM

PART A (to be completed by the Applicant)

	Applicant	Next of Kin	Alternate (emergency contact)
First Name			
Last Name			
Street Address			
City			
State/Country			
Post Code			
Home Phone			
Work Phone			
Date of Birth		Relationship to Applicant	Relationship to Applicant
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male		
Height			
Weight			

Are you covered by additional insurance other than that provided by goAUPAIR?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please describe:			
Have you ever had:	Yes	No	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
Epilepsy/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
German measles	<input type="checkbox"/>	<input type="checkbox"/>	Abortion
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
Glandular fever	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Depression
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Other
If you have answered yes to any of the above, please give details including dates, if possible:			
Have you ever undergone surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please give full details with dates:			
Is your physical activity restricted in any way?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received treatment for a nervous or emotional problem?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been treated by a psychiatrist?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently taking any medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any habits that affect your health? (alcohol, cigarettes, drugs, etc)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take oral contraceptives?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any chronic or recurring illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been tested for AIDS?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, have you ever been diagnosed HIV positive?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been tested for Hepatitis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, have you ever been diagnosed Hepatitis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have answered yes to any of the above, please give full details including the names of any medications:			

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PART B (to be completed by the Physician)

As an Au Pair, 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 or mental health issues that may have a bearing on the Applicant's ability to participate.

- A. Please review the information provided by the Applicant on the other side of this page.
 B. Please indicate whether the Applicant has been immunized against the following:

	Yes	No	Date
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
German measles (rubella)	<input type="checkbox"/>	<input type="checkbox"/>	
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculin test	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	

- C. Are there any abnormalities of the following systems?

	Yes	No		Yes	No
Head, ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Other					

If you have answered yes to any of the above, please give details if possible:

- D. Is the Applicant currently or recently been treated / counseled for a nervous condition, depression or emotional disorder? Yes No

If yes, please explain:

- E. Is there, in your opinion, any condition either physical or emotional which an American family might want to take into account when reaching a decision to have the Applicant live in their home and care for their small children for one year? Yes No

If yes, please explain:

How long have you treated this patient?

F. Comments

Name of Doctor <i>(please print)</i>	
Address	
Telephone	

Signature _____ Date _____