Physician's Report Form

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Part A (completed by the applicant)

1. Please print the entire form and fill out Part A completely. (This is a print-only form.)
2. Have your physician or doctor fill out Part B completely.
3. When the form is complete, give it to your International Representative so they can verify the physician and check that everything is completed correctly.

First Name _____ Last Name _____

Address _____ City _____

State/Country _____ Postal Code _____ Phone _____

Gender _____ Date of birth (mm/dd/yy) _____ Height _____ Weight _____

Next of Kin

First Name _____ Last Name _____

Address _____ City _____

State/Country _____ Postal Code _____ Phone _____

Relationship to applicant _____

Alternate Emergency Contact

First Name _____ Last Name _____

Address _____ City _____

State/Country _____ Postal Code _____ Phone _____

Relationship to applicant _____

Insurance and Medical History

Will you be covered by insurance other than that provided by Go Au Pair? YES ◯ NO ◯

If YES, please describe.

Have you ever had the following medical conditions?

Tuberculosis	YES ◯	NO ◯	Chicken pox	YES ◯	NO ◯
Asthma	YES ◯	NO ◯	Glandular fever	YES ◯	NO ◯
Diabetes	YES ◯	NO ◯	Malaria	YES ◯	NO ◯
Kidney disease	YES ◯	NO ◯	Eye problems	YES ◯	NO ◯
Heart disease	YES ◯	NO ◯	Ear infections/problems	YES ◯	NO ◯
Arthritis	YES ◯	NO ◯	Headaches	YES ◯	NO ◯

Medical conditions (continued)

Epilepsy/Seizures	YES ◯	NO ◯	Rheumatic fever	YES ◯	NO ◯
Scarlet fever	YES ◯	NO ◯	Anorexia	YES ◯	NO ◯
Measles	YES ◯	NO ◯	Bulimia	YES ◯	NO ◯
German measles	YES ◯	NO ◯	Dizziness/Fainting	YES ◯	NO ◯
Mumps	YES ◯	NO ◯	Anemia	YES ◯	NO ◯
Pregnancy	YES ◯	NO ◯	Gall bladder problems	YES ◯	NO ◯
Miscarriage	YES ◯	NO ◯	Depression/Anxiety	YES ◯	NO ◯
Abortion	YES ◯	NO ◯	Allergies	YES ◯	NO ◯
Menstrual problems	YES ◯	NO ◯	Herpes HSV1 (cold sore)	YES ◯	NO ◯
Ulcers	YES ◯	NO ◯	Other (specify below)	YES ◯	NO ◯

If you answered YES to any medical condition(s), please explain.

Have you ever had surgery? YES ◯ NO ◯

If YES, please give full details with dates.

Physical and Mental Health

Is your physical activity restricted in any way?	YES ◯	NO ◯	Do you have any chronic or recurring illnesses?	YES ◯	NO ◯
Have you ever received treatment for a nervous or emotional problem?	YES ◯	NO ◯	Do you take oral contraceptives?	YES ◯	NO ◯
Have you ever been treated by a psychiatrist?	YES ◯	NO ◯	Have you ever been tested for AIDS?	YES ◯	NO ◯
Do you currently take any medications?	YES ◯	NO ◯	If YES, were you diagnosed HIV positive?	YES ◯	NO ◯
Do you have any habits that affect your health? (alcohol, cigarettes, drugs, etc.)	YES ◯	NO ◯	Have you been tested for Hepatitis?	YES ◯	NO ◯
			If YES, were you diagnosed with Hepatitis?	YES ◯	NO ◯

If you answered YES to any of the above, please give details including dates if applicable.

Part B (completed by the physician)

The applicant will be living abroad for an extended period with a Host Family, while providing child care for the family. It is important that Go Au Pair be advised of any physical or mental health issues that may have a bearing on the applicant's ability to provide child care and participate in daily family activities. **Please review the information provided by the applicant and complete Part B of this form.**

How long have you treated this patient? _____

Comments

Is the applicant currently taking any medication(s)? YES ◯ NO ◯

If Yes, please explain.

Has the applicant currently or recently been treated/counseled for anxiety, depression or emotional disorder? YES ◯ NO ◯

If YES, please explain.

Immunizations

Has the applicant been immunized for the following? If YES, provide the date or estimated date. If the immunization was provided by your office, please select YES, Office Verified, and provide the Date of the immunization.

	YES	NO	Office Verified	Date (mm/dd/yy)
Tetanus	◯	◯	◯	_____
Diphtheria	◯	◯	◯	_____
Polio	◯	◯	◯	_____
Pertussis	◯	◯	◯	_____
Tuberculosis	◯	◯	◯	_____
Hepatitis	◯	◯	◯	_____

	YES	NO	Office Verified	Date (mm/dd/yy)
Typhoid	◯	◯	◯	_____
Mumps	◯	◯	◯	_____
German measles (rubella)	◯	◯	◯	_____
Measles	◯	◯	◯	_____
Other	◯	◯	◯	_____

Medical Test Verification

Please verify that the applicant has been tested by your office for the following. If YES, please indicate the test results and the Date of the test.

Test	YES	NO	Test Results		Date of Test (mm/dd/yy)
HIV/Aids	◯	◯	Positive ◯	Negative ◯	_____
Hepatitis	◯	◯	Positive ◯	Negative ◯	_____
Tuburculosis	◯	◯	Positive ◯	Negative ◯	_____

Medical Abnormalities

Are there any abnormalities of the following systems?

Head, ears, nose, throat	YES ◯	NO ◯	Respiratory	YES ◯	NO ◯
Eyes	YES ◯	NO ◯	Neuropsychiatric	YES ◯	NO ◯
Cardiovascular	YES ◯	NO ◯	Metabolic	YES ◯	NO ◯
Gastrointestinal	YES ◯	NO ◯	Genitourinary	YES ◯	NO ◯
Skin	YES ◯	NO ◯	Other	YES ◯	NO ◯
Musculoskeletal	YES ◯	NO ◯			

If you answered YES to any system abnormalities, please explain.

Does the applicant have a physical and/or any emotional conditions that an American Host Family should be aware of to determine if this applicant will be a good match for their family and child care needs?

Physician's Confirmation

Physician's Name (please print) _____ Phone _____

Address _____ City/Country _____

I certify that the information provided in this report is complete and accurate to the best of my knowledge.

Physician's Signature _____ Date _____

International Representative's Confirmation

I certify that this physician is a practicing physician in the Au Pair's area. Due to privacy laws surrounding medical treatment (HIPAA) I can not confirm any of the specific information contained.

International Representative's Signature _____ Date _____