



**Part A**  
**To be  
completed  
by the  
applicant**

Applicant Name \_\_\_\_\_

Alternate (Emergency Contact) \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State/Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to applicant \_\_\_\_\_

Gender  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

**A.** Are you covered by additional insurance other than that provided by Au Pair Foundation?

Yes  No (If yes, please describe) \_\_\_\_\_

**B.** Have you ever had?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers                | <input type="checkbox"/> Dizziness / fainting |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Anorexia        | <input type="checkbox"/> Gall bladder          | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Glandular fever | <input type="checkbox"/> Bulimia         | <input type="checkbox"/> Depression            | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Malaria         | <input type="checkbox"/> Measles         | <input type="checkbox"/> Allergies             | _____   |
| <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Eye problems    | <input type="checkbox"/> Anemia          | <input type="checkbox"/> German measles        | _____   |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Ear infection   | <input type="checkbox"/> Pregnancy       | <input type="checkbox"/> Menstrual problems    | _____   |
| <input type="checkbox"/> Scarlet fever  | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Miscarriage     | <input type="checkbox"/> Epilepsy / convulsion | _____   |

If you answer yes to any of the above please give details including dates if possible

Details\* \_\_\_\_\_ Date \_\_\_\_\_

**C.** Have you ever undergone surgery?  yes  no

Please give full details with date

Details\* \_\_\_\_\_ Date \_\_\_\_\_

**D.** Is your physical activity restricted in any way?  yes  no

**E.** Have you ever received treatment for nervous or emotional problems?  yes  no

**F.** Have you ever been treated by a psychiatrist?  yes  no

**G.** Are you currently taking any medications?  yes  no

**H.** Do you have any habits that affect your health?  yes  no

Alcohol  Cigarettes  Drugs \_\_\_\_\_ Other \_\_\_\_\_

**I.** Do you take oral contraceptives?  yes  no

**J.** Do you have any chronic or recurring illness?  yes  no

**K.** Have you ever been tested for AIDS?  yes  no

If yes, have you ever been diagnosed HIV positive?  yes  no

If you have answered yes to any of the above please give full details indicating the names of any medication

Details\* \_\_\_\_\_ Medication Name \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\* (if you need more space explaining details, please use the back of the page)



**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 page.**

**B. Please indicate whether the applicant has been immunized against the following:**

Tetanus  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Polio  Yes  No Date \_\_\_/\_\_\_/\_\_\_  
 Diphtheria  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Measles  Yes  No Date \_\_\_/\_\_\_/\_\_\_  
 Typhoid  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Mumps  Yes  No Date \_\_\_/\_\_\_/\_\_\_  
 Tuberculosis  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Whooping Cough  Yes  No Date \_\_\_/\_\_\_/\_\_\_  
 Have you received a BCG vaccine?  Yes  No Date \_\_\_/\_\_\_/\_\_\_

**C. Are there any abnormalities of the following system?**

Gastrointestinal  Yes  No  
 Skin  Yes  No Musculoskeletal  Yes  No  
 Metabolic  Yes  No Neuropsychiatric  Yes  No  
 Eyes  Yes  No Genitourinary  Yes  No  
 Other  Yes  No (if yes):

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

**E.** If yes, please explain\* \_\_\_\_\_  
 \_\_\_\_\_

**F.** 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\* \_\_\_\_\_  
 \_\_\_\_\_

**G.** How long have you treated this patient? \_\_\_\_\_

Comments\* \_\_\_\_\_  
 \_\_\_\_\_

**Name of doctor** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

**Date** \_\_\_/\_\_\_/\_\_\_ **Signature** \_\_\_\_\_

<b>For office use only • Medical Verification:</b>	
Verified by (print name): _____	
Date _____	Signature _____

\* (if you need more space explaining details, please use the back of the page)