AuPairCare

PHYSICIAN VERIFIED MEDICAL HISTORY

NOTE TO PHYSICIAN: The person presenting you with this form is applying to be an au pair with AuPairCare. If accepted, he/she will spend a year with an American family taking care of the family's children and being responsible for them. It is important that the people we entrust with this responsibility be in good health. Please provide in depth medical history and attach additional documentation if necessary.

Name of Patient: _____ Date of Birth: _____/_____/_____ (month/day/year)

Age: _____ Height: _____ Weight: _____

1. Does this patient have or have they ever suffered from or been diagnosed with any of the following? Indicate by checking "Yes" or "No" for each condition:

Yes	No		Yes	No		Yes	No	Any disease or abnormality of:	Yes	No	General health:
☐	☐	Anorexia	☐	☐	Meningitis	☐	☐	Blood or endocrine system	☐	☐	Genito-urinary issues
☐	☐	Allergies	☐	☐	Mumps	☐	☐	Bones, joints or locomotive	☐	☐	Mental or nervous disorders
☐	☐	Bulimia	☐	☐	Rubella	☐	☐	Brain or nervous system	☐	☐	Is the patient pregnant?
☐	☐	Chicken pox	☐	☐	Scarlet fever	☐	☐	Ears or hearing	☐	☐	Does the patient have any physical disabilities?
☐	☐	Diabetes	☐	☐	Serious or persistent cough	☐	☐	Eyes or sight	☐	☐	Does the patient have any contagious diseases?
☐	☐	Epilepsy	☐	☐	Serious or persistent headaches	☐	☐	Heart	☐	☐	Does the patient have an alcohol or drug dependency?
☐	☐	Hernia	☐	☐	Tuberculosis	☐	☐	Lungs or respiratory system	☐	☐	Does the patient suffer from panic attacks?
☐	☐	HIV/AIDS	☐	☐	Typhoid fever	☐	☐	Other abdominal organs	☐	☐	Does the patient smoke?
☐	☐	Hepatitis	☐	☐	Ulcer	☐	☐	Stomach or digestive	☐	☐	Other: _____
☐	☐	Measles	☐	☐	Vertigo/Dizziness	☐	☐	Tonsils, nose or throat			

If "Yes" is checked for any of the above conditions, please explain further and provide the year illness(es) occurred. If the exact year is unknown please provide an approximate year: _____

2. Please list all adult inoculations/vaccines/immunizations that have been given to this patient and the approximate month and year received:

3. Has this patient ever been hospitalized? ☐ Yes ☐ No If yes, please explain: _____

4. Has this patient been treated for a medical condition in the past 2 years? ☐ Yes ☐ No If yes, please explain: _____

5. Does this patient regularly take any medications (excluding birth control)? ☐ Yes ☐ No If yes, please explain: _____

6. Does this patient have any pre-existing medical conditions? ☐ Yes ☐ No If yes, please explain: _____

7. Has this patient ever received psychiatric counseling? ☐ Yes ☐ No If yes, please explain: _____

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8. Does the patient have any history or symptoms of an eating disorder such as anorexia, bulimia or other similar conditions? ☐ Yes ☐ No

If yes, please explain: _____

_____

9. Does the patient present any history or symptom of nervous, emotional, or mental abnormality (i.e. neurosis, nervous breakdown/fatigue, panic attacks, etc.)?

☐ Yes ☐No If yes, please explain:_____

_____

10. Does this patient suffer from any chronic conditions (i.e. asthma, arthritis, diabetes, epilepsy, chronic fatigue, etc.)? ☐ Yes ☐No

If yes, please explain:_____

_____

11. Has this patient ever been the victim of physical or sexual abuse? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

12. Is there any reason why this patient should not care for children? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

13. Is there anything more you would like to tell us about this patient? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

14. In my expert opinion, the general state of the patient's health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the patient.
I certify that the above information is complete and accurate to the best of my knowledge.

Physician's Name:_____

Phone Number:_____ Place Physician Stamp Here

Signature:_____

Date:_____/_____/_____ (month/day/year)

Emergency Operation Release/Waiver

If my medical condition changes (including pregnancy), between the time of signing this document and my departure to the USA, I understand that I am required to notify AuPairCare and resubmit another Physician Verified Medical History document prior to my arrival. I also understand that failure to adhere to this policy, will likely result in my immediate termination from the program. My signature below indicates that the medical history provided is true and hereby give my full consent to be medically treated or to undergo any emergency operation which is determined by a doctor and may be necessary during my stay abroad. I also accept full responsibility for any medical expenses which are not covered by my insurance policy, and understand that pre-existing medical conditions will not be covered. I also give my full consent to release this information to potential host families.

Strong recommendations to the au pair: Travel Insurance does not include the cost of normal dental treatment that is not due to an accident. It is therefore important for any person traveling abroad to receive a thorough dental examination so that no unexpected complications arise during the period of residence abroad.

Au Pair Signature: _____ Date: _____

Print Name: _____