EurAuPair
Intercultural Child Care Programs

Au Pair Medical Record Verification Form

EurAuPair
250 North Coast Highway
Laguna Beach, CA 92651
Telephone: (949) 444-5386

Applicant's Name:_____

Date of Birth:_____
DAY/MONTH/YEAR

Height (cm):_____ Weight (kg.):_____

Instructions: This reference must be completed by a **physician** and may be verified by an EurAupair representative. You (the physician) may be contacted by an EurAupair representative to confirm the information given.

1. Does the Applicant have any disease or abnormality:

☐ Eyes or Vision	☐ Locomotors System	☐ Respiratory system
☐ Ears or Hearing	☐ Bones, Joints	☐ Tonsils, Nose, Throat
☐ Nervous system	☐ Urine system	☐ Heart, Blood Vessels
☐ Abdomen	☐ Blood/Endocrine System	☐ Other (please specify)

Please provide detail information and dates regarding each of the diseases or abnormalities marked Y (yes):

2. Vaccination. Please indicate if the Applicant has been immunized against the following:

Vaccine	Yes	No	Date(s)
Tetanus	☐	☐	
Diphtheria	☐	☐	
Polio	☐	☐	
Measles	☐	☐	
Rubella (German measles)	☐	☐	
Typhoid	☐	☐	
Mumps	☐	☐	
Whooping cough	☐	☐	

3. Has Applicant been immunized against tuberculosis with the BCG vaccine: ☐ Yes ☐ No

Note: if the Applicant has not been immunized, he/she **must pass a TB skin** test done within the past year:
Skin test date:_____ Test result: ☐ Negative ☐ Positive

4. Is the Applicant currently suffering from or has he/she ever been treated for:

Depression disorder	☐ Yes ☐ No	Year _____
Eating Disorder	☐ Yes ☐ No	Year _____
Personality Disorder	☐ Yes ☐ No	Year _____
Learning or Speaking Disorder	☐ Yes ☐ No	Year _____

If answered Yes above, please provide detail information:

5. Has the Applicant to ever been hospitalized (if yes, please specify):

6. Does the Applicant currently suffer from or has he/she ever suffered from any of the following?

Illness:		*Disorders:*	
Chicken Pox	Yes☐ No☐ Year____	Allergies*	Yes☐ No☐ Year____
Measles	Yes☐ No☐ Year____	Asthma*	Yes☐ No☐ Year____
Mumps	Yes☐ No☐ Year____	Diabetes	Yes☐ No☐ Year____
Rubella	Yes☐ No☐ Year____	Enuresis	Yes☐ No☐ Year____
Malaria	Yes☐ No☐ Year____	Gall Stones	Yes☐ No☐ Year____
Hepatitis	Yes☐ No☐ Year____	Herpes	Yes☐ No☐ Year____
If yes, what type:	____	Parasites	Yes☐ No☐ Year____
Headaches	Yes☐ No☐ Year____	Seizure disorder	Yes☐ No☐ Year____
Hyper/Hypothyroidism	Yes☐ No☐ Year____	Dizziness	Yes☐ No☐ Year____
Hernia	Yes☐ No☐ Year____		

*If yes on allergies or asthma, please fill in an allergy statement and attach it to this document.

Other (please specify):____

7. Has the Applicant ever been the victim of sexual, emotional or physical abuse (if yes, please specify):

8. Does the Applicant have any physical and/or emotional health limitations that would limit her/his participation in providing healthcare (if yes, please explain)?

9. Is the Applicant currently taking any medications (please specify):

10. Is the Applicant allergic to any drugs? (Please list the drugs and their English substitute names) :

11. Other conditions or illness. Is there any other history of physical or emotional related problems or condition which a host family should be taken into account when reaching a decision to have the Applicant live in their home and care for their children for one year?

I, the undersigned, reviewed the medical history of Applicant and given a thorough physical examination. I certify that the above information is complete and accurate, and that all important medical information has been included in this form.

Daytime telephone:____ (COUNTRY CODE/AREACODE/LOCAL NUMBER) Evening telephone:____ (COUNTRY CODE/AREACODE/LOCAL NUMBER)

Signature:____ Date:____ (DAY/MONTH/YEAR)

Physician's Stamp or Stamp, and Signature:

Office use only: Verified by ____ **Date**: ____