Medical Form Part A

(to be completed by you and reviewed by your doctor)

Applicant's name: ____

Tick the appropriate boxes if you presently suffer from, or ever had:

❑ COVID-19 ❑ Tuberculosis ❑ Typhus ❑ Anaemia ❑ Arthritis ❑ Ulcers ❑ Venereal disease ❑ Herpes (cold sores) ❑ Kidney disease ❑ Malaria	❑ Chicken Pox ❑ Mumps ❑ Measles ❑ German measles ❑ Whooping Cough ❑ Diphtheria ❑ Tetanus ❑ Scarlet fever ❑ Polio	❑ Eye problems ❑ Heart disease ❑ menstrual problems ❑ Rheumatic fever ❑ Epilepsy/Convulsions ❑ Pregnancy/Miscarriage or Termination ❑ Hernia ❑ Varicose veins	❑ Asthma ❑ Ear infection ❑ Gall bladder problems ❑ Bulimia ❑ Anorexia ❑ Depression ❑ Sleep Walking ❑ Diabetes ❑ Anxiety	❑ Glandular Fever ❑ Migraines/headaches ❑ Dizziness / Fainting Hepatitis ❑ A ❑ B ❑ C ❑ other:____________ __________________

If you have ticked any of the above, give details including dates:

____

A condition of participating on this Program is you have been immunised against Measles, Mumps, German Measles (Rubella) and Chicken Pox. You also need to have been vaccinated against Tetanus, Diphtheria and Whooping Cough within the last 10 years.

Other than the completion of this form, have you visited the doctor or been hospitalised within the last 12 months, if yes, why?

____

Have you ever received counselling and /or medication for a nervous problem, eating disorder, depression or emotional problem?
❑ Yes ❑ No If yes, give details and dates:____

Have you ever been a victim of sexual, emotional or physical abuse? ❑ Yes ❑ No If yes, give details and dates:

____

Do you have any food allergies? ❑ Yes ❑ No If yes, please specify:
Do you have any allergies to animals? ❑ Yes ❑ No If yes, please specify:
Do you have any allergies to medications? ❑ Yes ❑ No If yes, please specify:
Do you have any other allergies ❑ Yes ❑ No If yes, please specify:

Do you have any habits which may affect your health (e.g. alcohol, cigarettes, drugs)? ❑ Yes ❑ No
Is your physical ability restricted in any way? ❑ Yes ❑ No
Do you carry any infectious diseases such as Hepatitis or the HIV virus in your blood? ❑ Yes ❑ No
Are you currently taking any medication? ❑ Yes ❑ No If yes, please specify:_______________
Do you have any chronic or recurring illnesses? ❑ Yes ❑ No If yes, please specify:_______________

I understand and agree that host families may have access to this medical information. I give permission to my Doctor completing Part B to review all my responses in Part A and to provide or discuss additional information, if requested to do so by AIFS.

Should an emergency arise, I authorise any medical provider to release information regarding my condition to AIFS, their partners or insurance providers / emergency assistance services and understand that they can contact my next kin, without my prior consent.

The above information is correct to the best of my knowledge and I hereby give permission for emergency medical care to take place should it be necessary. I also understand that withholding or falsifying any information contained on Part A & B may result in my withdrawal from the AIFS Au Pair program.

Signature______________________________________ Date_____________________________

Medical Form Part B

(to be completed by doctor)

Applicant's name: ____

How long have you known the applicant?___________________________________

Are you related to the applicant? ❑ Yes ❑ No (relatives may not complete this form)

Please review the information provided in Part A and give your opinion of the applicant's general state of health:
❑ Excellent ❑ Good ❑ Fair ❑ Poor

Immunizations

Please ensure that the applicant is currently immune to the following (by vaccination or after the illness):

Measles: Date of vaccination: ____________ / Date of illness: __________________
Mumps: Date of vaccination: ____________ / Date of illness: __________________
German Measles (Rubella) Date of vaccination: ____________ / Date of illness: __________________
Chicken Pox: Date of vaccination: ____________ / Date of illness: __________________
Diphtheria Date of vaccination:_____________
Tetanus Date of vaccination:_____________
Whooping Cough Date of vaccination: ____________ / Date of illness: __________________
Immunity to Whooping Cough after the illness needs to be proven by blood test.
Date of positive blood test:___________

Please also indicate whether the applicant has been immunized against the following:

Polio ❑ Yes ❑ No Date: __________
Tuberculosis(TB) ❑ Yes ❑ No Date: __________
Typhoid ❑ Yes ❑ No Date: __________
Covid-19 ❑ Yes ❑ No Dates: __________

General Health

Tick the appropriate box if there are any abnormalities to the following systems:

❑ Ear, nose and throat ❑ Eyes ❑ Neuropsychiatric ❑ Metabolic
❑ Genitourinary ❑ Skin ❑ Cardiovascular ❑ Musculoskeletal
❑ Brain, nervous system ❑ Gastrointestinal ❑ Respiratory system/lungs ❑ Other

If you have ticked any of the above, please give details and dates:____
____

Emotional Health

Is the applicant currently or has ever been treated /counseled or received medication for a nervous condition, eating disorder, depression or emotional problem? ❑ Yes ❑ No
If yes, give details and dates and comment on the applicant's present emotional well being:____________________
____

Does the applicant have any history of physical, emotional or sexually related problems (i.e. abuse)? ❑ Yes ❑ No
If yes, please comment: ____

Contagious Diseases

Is the applicant, to the best of your knowledge, a likely carrier of any infectious disease such as Hepatitis B or C, or the HIV virus? (The applicant does not need to be tested) ❑ Yes ❑ No
Has the applicant been hospitalized for more than three days? ❑ Yes ❑ No
If you have ticked yes above, please give details and dates, if applicable: ______________________________
____

Please use this space to give any additional relevant information:_______________________________________
____

Name of Doctor:____

Address:____Telephone No.:____________________________

Signature and practice stamp:_________________________________Date: ____________________________