



OPENING DOORS TO THE WORLD SINCE 1980!

• **CULTURAL HOMESTAY INTERNATIONAL** •

A NON-PROFIT EDUCATIONAL EXCHANGE PROGRAM

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AU PAIR MEDICAL INFORMATION

“OPEN YOURSELF TO THE WORLD, THE WORLD WILL BECOME YOUR HOME”

PHYSICIAN’S STATEMENT OF HEALTH

THIS PAGE MUST BE COMPLETED AND CONFIRMED BY THE EXAMINING PHYSICIAN. PLEASE ANSWER ALL QUESTIONS.

Name of patient: _____ Date of Birth (mm/dd/yyyy) ___/___/___

Male Female

Does the patient have any of the following? If yes, give date of illness and detailed information regarding any impairment in the space provided below.

	Yes	No	Year		Yes	No	Year
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>		Allergies*	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>		Asthma*	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>		Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>		Cough (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	<input type="checkbox"/>		Enuresis	<input type="checkbox"/>	<input type="checkbox"/>	
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid abnormality (Struma)	<input type="checkbox"/>	<input type="checkbox"/>	
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		Headache (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Parasites (intestinal, other)	<input type="checkbox"/>	<input type="checkbox"/>		Learning or Speech Defect	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Vertigo, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>		Other (please indicate)_____	<input type="checkbox"/>	<input type="checkbox"/>	

* If yes, physician must attach statement describing allergy, allergen, medication sensitivity, symptoms, treatment, medications and expected future treatment.

Any disease, impairment or abnormality of any of the following:

	Yes	No		Yes	No
Abdominal Organs, Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>
Bones, Joints, Locomotor System	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>
Blood, Endocrine System	<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>
Brain, Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>
Ears or Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Skin (Acne, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils, Nose or Throat	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

- Will patient be using any prescription drugs/medication while in the U.S. ? Yes No
Has patient ever been hospitalized? Yes No
Has patient ever consulted a neurologist? Yes No
Has patient ever consulted a psychologist? Yes No
Has patient ever consulted any other kind of specialist? Yes No

If yes, to any of the above, please give details in English: _____

PHYSICIAN'S STATEMENT OF HEALTH

Name of patient: _____ Date of Birth (mm/dd/yyyy) ____/____/____

Give your opinion of the general state of the candidate's health:

- Excellent Good Fair Poor

Blood Group:

- A B AB O

RH Factor:

- Rh positive Rh negative

If the patient wears glasses or contact lenses, please complete the following ophthalmic information:

	Sphere	Cylinder	Axis	Prism	Base
(OD) Ocular Dexter					
(OS) Ocular Sinister					

CURRENT T.B EXAMINATION *(Must have been completed within the last three (3) years.)*

B.C.G. Vaccination (mm/yyyy): ____/____

If BCG Vaccination given, chest X-ray results must be provided.

TB Skin Test Date (mm/yyyy): ___/___/___

Results: Negative

Positive

If positive, chest X-ray results must be provided.

Subject: Results of Chest X-ray – examination date (mm/yyyy): ___/___/___

IMMUNIZATION

Please put the date of the most recent booster. Important: for DT and Polio is mandatory every 10 years.

Vaccine	Most Recent Dose Given (MM/YY)
DTP and/or DT (Diphtheria, Tetanus and Pertussis) or (Whooping cough) or (Tetanus and Diphtheria only)	___/___
Polio Myelitis	___/___
Measles (Rubeola -10 days measles)	___/___
Rubella (German Measles – 3 day measles)	___/___
Mumps	___/___

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the candidate and certify that all important medical information has been included and that the above information is accurate.

PHYSICIAN'S NAME (TYPE OR PRINT): _____

ADDRESS: _____

PHYSICIAN'S SIGNATURE: _____ **DATE (MM/DD/YYYY)** ___/___/___

STAMP OR PHYSICIANS'S #: _____

PARTICIPANT'S SIGNATURE: _____ **DATE (MM/DD/YYYY)** ___/___/___