

Medical Report Form

Please fill in the form in CAPITAL ENGLISH LETTERS.

A. TO BE COMPLETED BY THE AU PAIR

Full name of the applicant: _____

Nationality _____ Date of Birth _____

Gender _____ Passport number _____

Height _____ Weight _____

Home address _____

English speaking emergency contact information.

Please describe name, relationship to applicant, mailing address, email and phone number.

For the time you plan to be an Au Pair in China, have you taken out any insurance other than that provided by Aupairia? Yes No

If yes, the name of insurance _____, Insurance type: _____,

The provider: _____, the expiration date: _____

Is your physical activity restricted in any way? Yes No

If yes, please explain: _____

Can you confirm that you are aware of the current recommended vaccinations for travelling to China and understand that it is your responsibility to arrange any you deem necessary prior to travelling?

Yes No

APPLICANT'S CONSENT

I give my consent for my physician to disclose any conditions that they believe preclude me from undertaking my duties as an Au Pair in China.

Signed by _____ (applicant) Date: _____

B. TO BE COMPLETED BY THE PHYSICIAN (Please fill in the form in CAPITAL ENGLISH LETTERS)

Physician's name: _____

Telephone (Country code+area code+ number): _____

Email: _____

Address: _____

Immunizations: (please indicate whether the Au Pair been immunized against the following and the date of immunization)

Doctor's Signature and Stamp: _____ **Date:** _____

<input type="checkbox"/> Hepatitis A	Date:
<input type="checkbox"/> Typhoid	Date:
<input type="checkbox"/> Hepatitis B	Date:
<input type="checkbox"/> Japanese Encephalitis	Date:
<input type="checkbox"/> Polio	Date:
<input type="checkbox"/> Rabies	Date:
<input type="checkbox"/> Yellow Fever	Date:
<input type="checkbox"/> Diphtheria	Date:
<input type="checkbox"/> Tetanus	Date:
<input type="checkbox"/> Measles	Date:
<input type="checkbox"/> Mumps	Date:
<input type="checkbox"/> Rubella	Date:
<input type="checkbox"/> Tuberculin test	Date:
<input type="checkbox"/> Whooping cough	Date:

Any other immunized items:

Date:

Has the Au Pair applicant ever suffered from:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Any kind of addiction such as alcohol or drugs
<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken pox
<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (any kind)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles
<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps
<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio
<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever
<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies
<input type="checkbox"/> Yes <input type="checkbox"/> No	Infectious diseases
<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV

Doctor's Signature and Stamp: _____

Date: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysteria
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe stutter
<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant hearing loss
<input type="checkbox"/> Yes <input type="checkbox"/> No	Reading or writing disabilities
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blind or partially blind
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other conditions

If you have answered yes to any of the above, please give full details including dates if possible here:

Is the applicant currently or recently been treated / counseled for a nervous condition, depression or emotional disorder? Yes No

If yes, please explain:

How long have you treated this patient?

Can you confirm that to the best of your knowledge the applicant is physically and psychologically fit to travel and take on childcare responsibilities as an Au Pair in China? Yes No

(Their role as an Au Pair applicant will be required to undertake potentially lengthy travel and live within a Host Family of children and elders for up to twelve months.)

If you have answered no please can you give details of relevant conditions which would make this applicant unsuitable for this post?

I confirm that the Au Pair applicant is in good general physical and psychological health, and that an ordinary clinical examination has shown no definite symptoms of illness that she/he suffers from any infectious or chronic disease, there is no objection to her/him associating with children.

For office uses:

To the best of my knowledge this doctor is qualified and licensed to practice medicine.

Verified by a Aupairia representative or international partner: _____

Date: _____

Doctor's Signature and Stamp: _____ **Date:** _____