Elite Au Pairs
An exciting gap year experience

Doctor's Medical Certificate for Au Pair Programme

To be completed by your Doctor

Surname: **First name:** **Female:** **Male:**

Date of birth: day month year **Height:** metres **Weight:** kilos

Address:

1. Does the applicant presently suffer from or has ever had the following?

	Yes	No		Yes	No		Yes	No
Allergies:			**Anaemia:**			**Anorexia:**		
Apendicitis:			**Arthritis:**			**Asthma:**		
Bulimia:			**Chicken Pox:**			**Depression:**		
Diabetes:			**Diziness/Fainting:**			**Eye problems:**		
Epilepsy/Convulsions:			**German Measles (Rubella):**			**Glandular Fever:**		
Heart Disease:			**Hepatitis:**			**Hernia:**		
Herpes (cold sores):			**Kidney Disease:**			**Malaria:**		
Measles:			**Menstrual problems:**			**Miscarriage:**		
Migraine/Headaches:			**Mumps:**			**Nervous Illness:**		
Polio:			**Rheumatic Fever:**			**Scarlet Fever:**		
Tuberculosis:			**Venereal Disease:**			**Ulcers:**		

If answered Yes to any of the above, please give details and dates as applicable:

2. Please indicate if the applicant has been immunised against the following:

	Yes	No	Date		Yes	No	Date
Tetanus:				**Mumps:**			
Typhoid:				**Measles:**			
Diptheria:				**Whooping Cough:**			
Tuberculin Test:				**German Measles (Rubella):**			
Polio:							

3. Is the applicant currently, to the best of your knowledge, a likely carrier for any infectious disease, such as Hepatitis B or HIV virus? **Yes** **No**
If answered yes, please give details:

4. Is the applicant currently, or has the applicant ever been treated/councelled or received medication for a nervous condition, eating disorder, depression or emotional disorder? **Yes** **No**
If answered yes, please give full details and dates. Please provide comments on the applicant's present condition and well being:

5. Has the applicant, to be best of your knowledge, ever had any criminal convictions or charges filed against them? **Yes** **No**
If answered yes, please give full details.:

6. Does this applicant have any history of physical, emotional or sexually related problems that you might wish a family to know as they consider whether the applicant is a suitable person to live in their home and care for their small children for up to 2 years? **Yes** **No**
If answered yes, please give full details:

Name of doctor:

Address:

Tel:

Fax:

Doctor's stamp or seal of the practice:

Signature:

Date:

_____ day **_____month** **_____year**