Cultural Care Au Pair

Au pair number (for CCAP office use only)

Physician's Health Evaluation

To the physician: This applicant is applying to travel abroad for up to two years and will be responsible for providing full time childcare in a home environment. Please note that **all questions on this form must be answered** for the applicant to be accepted to the program.

Patient/Applicant Name: _____

Date of Birth: _____ _____ _____ Gender: Female ☐ Male ☐ Height: _____ Weight: _____

Medical History

If the answer to any of questions 1-11 is "YES", please review the attached cover letter and complete an additional medical note describing the issue/condition, dates of treatment (start, end, ongoing), outcome of treatment if concluded, health today and how it may impact the applicant's ability to care for children full time.

1. In my expert opinion the **general state** of the patient's health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Is the applicant **currently** taking any medicine or is the applicant undergoing any treatment? ☐ No ☐ Yes
   If yes, please specify **which medicine or treatment:** _____
   If yes, please specify what the **medicine or treatment is for:** _____
3. In the **last 12 months**, has the applicant been **hospitalized or had surgery**? ☐ No ☐ Yes, please specify:
4. In the **last two years** has the applicant received any medicine or undergone any treatment? ☐ No ☐ Yes
   If yes, please specify **which medicine or treatment**: _____
   If yes, please specify what the **medicine or treatment is for**: _____
5. Has the applicant had any history of **compulsive, mental, nervous or stress related issues**? ☐ No ☐ Yes, please specify:
6. Does the applicant have any **visual impairment**? ☐ No ☐ Yes, please specify (for glasses or contact lenses, further medical note not required):
7. Does the applicant have any **hearing impairment**? ☐ No ☐ Yes, please specify:
8. Does the applicant have any illness or condition with is **contagious or communicable**? ☐ No ☐ Yes, please specify:
9. Does the applicant have any **chronic disease** such as epilepsy, diabetes etc.? ☐ No ☐ Yes, please specify:
10. Is there evidence of any other **disease, impairment or abnormality**? ☐ No ☐ Yes, please specify:
11. Any **additional information** to add regarding the health of the applicant? ☐ No ☐ Yes, please specify:

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ILLNESS AND IMMUNIZATION HISTORY

Tuberculosis:

Has the applicant received a BCG vaccine? ☐ No ☐ Yes, on date YYYY

If candidate has NOT received BCG vaccine, please provide one of following test results:

	Date	Result (positive = TB/negative = no TB)
TB test (only valid if within last 12 months):		
Chest x-ray (only valid if within last 3 months):		

If candidate previously diagnosed with active tuberculosis, please attach a medical note.

Hepatitis

Has the applicant had a history of any of these forms of Hepatitis?

Hepatitis A: ☐ No ☐ Yes (please specify, including date): _____

Hepatitis B: ☐ No ☐ Yes (please specify, including date): _____

Hepatitis C: ☐ No ☐ Yes (please specify, including date): _____

Immunizations:

This section must be completed in full. Copies of immunization cards/booklets are NOT accepted. Please do not leave any section unanswered/ blank. Please include the **YEAR OF IMMUNIZATION/DISEASE.**

	Date of Immunization	Date of Disease	Check if NO Disease/ Immunization
Diptheria	YYYY	YYYY	
Tetanus	YYYY	YYYY	
Pertussis	YYYY	YYYY	
Polio	YYYY	YYYY	

	Date of Immunization	Date of Disease	Check if NO Disease/ Immunization
Mumps	YYYY	YYYY	
Rubella	YYYY	YYYY	
Measles	YYYY	YYYY	
Chickenpox	YYYY	YYYY	

If you have checked **NO** for any of the above, please explain why (e.g., religious beliefs, medical reasons, etc.)

_____

_____

Are you a family member of this patient? ☐ No ☐ Yes, please indicate your relationship:

_____

Physician's signature: Date: _____ _____ _____

_____

Phone number:

_____

PHYSICIAN'S OFFICE STAMP

FOR CCAP OFFICE USE ONLY

Health certificate checked by (name): _____ Date: _____

Additional comments:

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