Please return your forms to
JCR Cultural Exchange
Programs (Pty) Ltd,
Postnet#88, Private Bag
X033, Rivonia, 2128.
Fax (011)4642973.
Tel (011) 4642975
www.jcr.co.za

PHYSICIAN'S REPORT FORM

PART A ***(to be completed by the Applicant)***

	Applicant	Next of Kin	Alternate *(emergency contact)*
First Name			
Last Name			
Street Address			
City			
State/Country			
Post Code			
Home Phone			
Work Phone			
Date of Birth		Relationship to Applicant	Relationship to Applicant
Sex	☐ Female ☐ Male		
Height			
Weight			

Are you covered by additional insurance other than that provided by goAUPAIR?	☐ Yes ☐ No
Please describe:	

Have you ever had:	Yes	No		Yes	No
Tuberculosis	☐	☐	Headaches	☐	☐
Asthma	☐	☐	Rheumatic fever	☐	☐
Diabetes	☐	☐	Anorexia	☐	☐
Kidney disease	☐	☐	Bulimia	☐	☐
Heart disease	☐	☐	Dizziness/fainting	☐	☐
Arthritis	☐	☐	Venereal disease	☐	☐
Epilepsy/convulsions	☐	☐	Anemia	☐	☐
Scarlet fever	☐	☐	Pregnancy	☐	☐
Measles	☐	☐	Miscarriage	☐	☐
German measles	☐	☐	Abortion	☐	☐
Mumps	☐	☐	Menstrual problems	☐	☐
Chicken pox	☐	☐	Ulcers	☐	☐
Glandular fever	☐	☐	Gall bladder problems	☐	☐
Malaria	☐	☐	Depression	☐	☐
Eye problems	☐	☐	Allergies	☐	☐
Ear infections	☐	☐	Other	☐	☐

If you have answered yes to any of the above, please give details including dates, if possible:	
Have you ever undergone surgery?	☐ Yes ☐ No
Please give full details with dates:	

Is your physical activity restricted in any way?	☐ Yes ☐ No
Have you ever received treatment for a nervous or emotional problem?	☐ Yes ☐ No
Have you ever been treated by a psychiatrist?	☐ Yes ☐ No
Are you currently taking any medications?	☐ Yes ☐ No
Do you have any habits that affect your health? (alcohol, cigarettes, drugs, etc)	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
Do you have any chronic or recurring illness?	☐ Yes ☐ No
Have you ever been tested for AIDS?	☐ Yes ☐ No
If yes, have your ever been diagnosed HIV positive?	☐ Yes ☐ No
Have you ever been tested for Hepatitis?	☐ Yes ☐ No
If yes, have your ever been diagnosed Hepatitis?	☐ Yes ☐ No

PHYSICIAN'S REPORT FORM

If you have answered yes to any of the above, please give full details including the names of any medications:	

PART B ***(to be completed by the Physician)***

As an Au Pair, the Applicant will be living for an extended period of time in the home of a family with young children. It is therefore important that we are advised of any physical or mental health issues that may have a bearing on the Applicant's ability to participate.

A. Please review the information provided by the Applicant on the other side of this page.
B. Please indicate whether the Applicant has been immunized against the following:

	Yes	No	Date
Tetanus	Í	Í	
Diphtheria	Í	Í	
Polio	Í	Í	
Measles	Í	Í	
German measles (rubella)	Í	Í	
Typhoid	Í	Í	
Tuberculin test	Í	Í	
Mumps	Í	Í	
Whopping cough	Í	Í	

C. Are there any abnormalities of the following systems?

	Yes	No		Yes	No
Head, ears, nose, throat	Í	Í	Musculoskeletal	Í	Í
Respiratory	Í	Í	Metabolic	Í	Í
Cardiovascular	Í	Í	Neuropsychiatric	Í	Í
Gastrointestinal	Í	Í	Eyes	Í	Í
Skin	Í	Í	Genitourinary	Í	Í
Other					

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

D. Is the Applicant currently or recently been treated / counseled for a nervous condition, depression or emotional disorder?	Í Yes Í No
If yes, please explain:	

E. Is there, in your opinion, any condition either physical or emotional which an American family might want to take into account when reaching a decision to have the Applicant live in their home and care for their small children for one year?	Í Yes Í No
If yes, please explain:	
How long have you treated this patient?	

F. Comments	

Name of Doctor *(please print)*	
Address	
Telephone	

Signature _____ Date _____