

**TRAWELL
Service**

Au pair a jazykové pobyty
www.trawell.sk



Au Pair Medical Form

PART A - To be completed by the applicant and reviewed by the applicant's Doctor

Applicant

First name	
Last name	
Initials	
Home Address	
Country	
Home Telephone No.	
Date of Birth	
Sex	
Height	
Weight	

Next of Kin (please give details of the relative or person we can contact in case of emergency)

Name	
Address	
Country	
Relationship to Applicant	
Telephone No (Day & Night)	

Are you covered by medical insurance?	
If yes, give details and attach a copy of the policy documents.	

Tick all that you presently suffer from or have ever had

- | | | | |
|-------------------------|--------------------------|------------------------|--------------------------|
| • Tuberculosis | <input type="checkbox"/> | • Mumps | <input type="checkbox"/> |
| • Migraine | <input type="checkbox"/> | • Sleep Walking | <input type="checkbox"/> |
| • Chicken Pox | <input type="checkbox"/> | • Bulimia | <input type="checkbox"/> |
| • Headaches | <input type="checkbox"/> | • Ear Infections | <input type="checkbox"/> |
| • Venereal Disease | <input type="checkbox"/> | • Epilepsy | <input type="checkbox"/> |
| • Ulcers | <input type="checkbox"/> | • Heart Disease | <input type="checkbox"/> |
| • Asthma | <input type="checkbox"/> | • Arthritis | <input type="checkbox"/> |
| • Scarlet fever | <input type="checkbox"/> | • Hepatitis | <input type="checkbox"/> |
| • Anaemia | <input type="checkbox"/> | • Herpes | <input type="checkbox"/> |
| • Diabetes | <input type="checkbox"/> | • Polio | <input type="checkbox"/> |
| • Rheumatic Fever | <input type="checkbox"/> | • Menstrual Problems | <input type="checkbox"/> |
| • Gall Bladder Problems | <input type="checkbox"/> | • Varicose Veins | <input type="checkbox"/> |
| • Malaria | <input type="checkbox"/> | • German Measles | <input type="checkbox"/> |
| • Measles | <input type="checkbox"/> | • Hernia | <input type="checkbox"/> |
| • Kidney Disease | <input type="checkbox"/> | • Miscarriage | <input type="checkbox"/> |
| • Anorexia | <input type="checkbox"/> | • Myoencephalitis (ME) | <input type="checkbox"/> |
| • Eye Problems | <input type="checkbox"/> | • Pregnant | <input type="checkbox"/> |
| • Depression | <input type="checkbox"/> | | |

If you have answered yes to any of the above give details including dates as applicable.

Have you needed to see a Doctor about anything recently (within the last six months)?	
If yes, give details of each visit	
Have you ever received counselling and/or medication for any nervous or emotional problem or an eating disorder?	
If yes, give full details and dates.	
Have you ever undergone surgery or been hospitalised?	
If yes, give full details and dates.	

Do you suffer from any allergies?	
If yes, give details	
Is your physical activity restricted in any way?	
Are you currently taking any medications?	
Do you have any habits which may affect your health (drugs, excessive alcohol intake, etc)?	
Do you have any chronic or recurring illness?	
Do you have any infectious diseases such as Hepatitis B or HIV?	

The above information is correct to the best of my knowledge and I hereby give permission for emergency medical care to take place should it be necessary.

Applicant's signature:

Date:

Duly assisted by:

Legal guardian (if under the age of 21)

Date:

Part B - To be completed by Doctor

As an au-pair the applicant will be living for an extended period of time in the home of a family with a young child. It is therefore important that we are advised of any physical, mental or emotional health problems or family history issues, which may have a bearing on the applicant's ability to carry out their duties appropriately.

Please review the information provided by the applicant, and give your opinion of the applicant's general state of health.

Excellent Good Fair Poor

Please indicate whether the applicant has been immunised against the following			
	Yes	No	Date
Tetanus			
Typhoid			
Diphtheria			
Tuberculin test			
Polio			
Mumps			
Measles			
Whooping Cough			
German Measles (Rubella)			

Are there any abnormalities to the following systems?		
	Yes	No
Ear, Nose and Throat		
Eyes		
Neuropsychiatric		
Respiratory System / Lungs		
Genito - Urinary		
Skin		
Cardio-Vascular		
Musculo-Skeletal		
Brain, Nervous System		
Gastrointestinal		
Metabolic		
Other		

If you have answered yes to any of the above, please give full details

<p>Is the applicant to the best of your knowledge, a likely carrier for any infectious diseases such as Hepatitis B or HIV, etc? If yes give details.</p>	
<p>Is the applicant currently or has the applicant ever been treated / counselled or received medication for a nervous condition, eating disorder, depression or emotional disorder?</p>	
<p>If yes, please give full details and dates. Please provide comments on the applicants present emotional well being.</p>	
<p>Is there in your opinion, any adverse reason, either physical, emotional or relative to family or to social background (such as a history of abuse) which a family might wish to know when considering whether the applicant is a suitable person to live in their home and care for their children for a year?</p>	
<p>If yes, please comment</p>	
<p>Have you any knowledge that the applicant has ever been a victim of physical or sexual abuse?</p>	

Please use this space to give any additional relevant information

I have examined (Applicant's name) and I find her / him to be capable of employment as an au pair.

Name of Doctor	
Address:	
Telephone number	
Office Hours	
Do you speak English?	
If no, did you fully understand all the questions asked on this form?	

Date _____

Signature _____

Please add the address stamp or seal of the practice to the Doctor's signature

This Medical Form should be returned to:

TRAWELL Service
Gúgska 27
940 82 Nové Zámky 1

Tel./Fax: 035-6414 556

E-mail: info@trawell.sk
Web: www.trawell.sk