

## CERTIFICATE OF HEALTH

(Please print clearly)

Name: \_\_\_\_\_  
Last
First
Middle

Address: \_\_\_\_\_  
Street/Postal Box

\_\_\_\_\_

City
State/Province
Zip/Postal Code
Country

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Identification Number: \_\_\_\_\_  
Day
Month
Year
( Office Use Only)

The candidate named above has applied for participation in an Au Pair Exchange Visitor Program in the United States of America through an international exchange organization dedicated to fostering cultural enrichment and intercultural understanding through youth exchange programs. If accepted for program participation, the applicant will spend a year living with an American host family, joining in their home life, providing child care assistance (45 hours each week), and attending a U.S. post-secondary educational institution. U.S. government regulations require au pair exchange program participants to demonstrate that they are fully capable of participating in this program.

**HAS THE APPLICANT HAD THE FOLLOWING ILLNESSES/CONDITIONS:**

- |  |   |  |
|--|---|--|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> ALLERGIES</p> <p><input type="checkbox"/> <input type="checkbox"/> APPENDICITIS</p> <p><input type="checkbox"/> <input type="checkbox"/> APPENDIX REMOVED</p> <p><input type="checkbox"/> <input type="checkbox"/> ASTHMA</p> <p><input type="checkbox"/> <input type="checkbox"/> CHICKEN POX</p> <p><input type="checkbox"/> <input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> <input type="checkbox"/> DRUG/ALCOHOL ABUSE</p> <p><input type="checkbox"/> <input type="checkbox"/> ENURESIS</p> <p><input type="checkbox"/> <input type="checkbox"/> EPILEPSY</p> <p><input type="checkbox"/> <input type="checkbox"/> HEPATITIS</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> HERNIA</p> <p><input type="checkbox"/> <input type="checkbox"/> HERNIA SURGERY</p> <p><input type="checkbox"/> <input type="checkbox"/> MALARIA</p> <p><input type="checkbox"/> <input type="checkbox"/> MUMPS</p> <p><input type="checkbox"/> <input type="checkbox"/> PARASITES</p> <p><input type="checkbox"/> <input type="checkbox"/> POLIO</p> <p><input type="checkbox"/> <input type="checkbox"/> PERSISTENT COUGH</p> <p><input type="checkbox"/> <input type="checkbox"/> PERSISTENT HEADACHES</p> <p><input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER</p> <p><input type="checkbox"/> <input type="checkbox"/> RUBELLA</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> SCARLET FEVER</p> <p><input type="checkbox"/> <input type="checkbox"/> SMALLPOX</p> <p><input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS</p> <p><input type="checkbox"/> <input type="checkbox"/> TYPHOID</p> <p><input type="checkbox"/> <input type="checkbox"/> VERTIGO, DIZZINESS</p> <p><input type="checkbox"/> <input type="checkbox"/> OTHER CONTAGIOUS DISEASES</p> |
|--|---|--|

**ANY DISEASE, IMPAIRMENT, ABNORMALITY:**

- |   |   |
|---|---|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> BLOOD OR ENDOCRINE SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> BONES, JOINTS OR LOCOMOTOR SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> BRAIN OR NERVOUS SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> EARS OR HEARING</p> <p><input type="checkbox"/> <input type="checkbox"/> EYES OR SIGHT</p> <p><input type="checkbox"/> <input type="checkbox"/> GENITO-URINARY SYSTEM</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART OR BLOOD VESSELS</p> <p><input type="checkbox"/> <input type="checkbox"/> LUNGS, RESPIRATORY SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> OTHER ABDOMINAL ORGANS</p> <p><input type="checkbox"/> <input type="checkbox"/> SKIN (ACNE, ETC.)</p> <p><input type="checkbox"/> <input type="checkbox"/> STOMACH OR DIGESTIVE SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> TONSILS, NOSE OR THROAT</p> |
|---|---|

**HAS THE APPLICANT BEEN TREATED BY A PHYSICIAN, PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR FOR:**

- |   |  |
|---|--|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> SCHIZOPHRENIA</p> <p><input type="checkbox"/> <input type="checkbox"/> DEPRESSION</p> <p><input type="checkbox"/> <input type="checkbox"/> MANIC DEPRESSIVE DISORDER</p> <p><input type="checkbox"/> <input type="checkbox"/> ANXIETY DISORDER</p> <p><input type="checkbox"/> <input type="checkbox"/> HYPERACTIVITY/ATTENTION DEFICIT DISORDER</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> EATING DISORDER</p> <p><input type="checkbox"/> <input type="checkbox"/> PERSONALITY DISORDER</p> <p><input type="checkbox"/> <input type="checkbox"/> POST TRAUMATIC STRESS</p> <p><input type="checkbox"/> <input type="checkbox"/> LEARNING DISABILITY</p> <p><input type="checkbox"/> <input type="checkbox"/> CONDUCT DISORDER</p> |
|---|--|

Please give full information (including dates and details) about every disease or impairment mentioned ("Yes" response) for any of the above questions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

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Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Pulse Rate: \_\_\_\_\_ Is pulse rhythm normal?  Yes  No If no, please explain: \_\_\_\_\_

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Blood Pressure: Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_

Are pupillary and knee reflexes normal?  Yes  No If no, please explain: \_\_\_\_\_

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What is the participant's vision: Without Correction: OD: \_\_\_\_\_ OS: \_\_\_\_\_

With Corrective Lenses: OD: \_\_\_\_\_ OS: \_\_\_\_\_

Does the applicant have any allergies or dietary restrictions?  Yes  No If yes, please describe them and explain how the applicant can/would deal with them in a host family setting?

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Has the participant ever been hospitalized?  Yes  No If yes, please give date(s), diagnosis and outcome.

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Is there a history of child abuse in the applicant's family?  Yes  No If yes, please explain: \_\_\_\_\_

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Does the participant have any health limitations (physical or emotional) or do you know of any pertinent information that is important for the Program to know that would limit her/his participation in normal school, family, sports or community life, including providing child care assistance for an American host family?  Yes  No

If yes, please explain:

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Is the participant currently receiving any injections or taking any medication?  Yes  No If yes, please give name(s) of medication(s) and injections and diagnosis.

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Will the participant require any orthodontic care during the coming year?  Yes  No If yes, attach a statement from the orthodontist, indicating present status, exact care essential to the orthodonture and date care will be completed. (Orthodontic work may not be covered under the Program's Medical Insurance.)

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Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

If the participant is female, does she have any problems in connection with her menstruation?  Yes  No  
If yes, please explain how this affects her normal activities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF IMMUNIZATIONS/VACCINATIONS**

Vaccine/Test	Date (month/year)	Date (month/year)	Date (month/year)	Date (month/year)	Date (month/year)
Diphtheria	1	2	3	4	5
Polio - Vaccine Type	1	2	3	4	5
Tetanus/Toxoids (Td)	1	2	3	4	5
Pertussis	1	2	3	4	5
Mumps	1	2	3	4	5
Rubella	1	2	3	4	5
Measles (Rubeola)	1	2	3	4	5
Tuberculosis (Mantoux Test or BCG Test)	1	2	3	4	5
Smallpox	1	2	3	4	5
Typhoid	1	2	3	4	5
Cholera	1	2	3	4	5
Yellow Fever	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

