DOCTORS MEDICAL CERTIFICATE

Surname (as stated in passport:	M/F
First name (as stated in passport):	
Date of birth:	Place of birth:
Height:	Weight:
Telephone number:	Mobile number:

1. Does the applicant presently suffer from or has the applicant ever had any of 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:**	☐	☐	

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Diptheria:	☐ ☐		**Whooping Cough:**	☐ ☐	
Tuberculin Test:	☐ ☐		**German Measles (Rubella):**	☐ ☐	
Polio:	☐ ☐				

diseases such as HIV virus or Hepatitis B?

Yes ☐ No ☐

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

_____

_____

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4. Is the applicant currently, or has the applicant ever, to the best of your knowledge received treatment/counselling for eating disorders, nervous disorders, depression or any emotional condition?

Yes ☐ No ☐

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

_____

_____

_____

_____

5. Has the applicant ever, or to the best of your knowledge, been treated for self harming? Does the candidate exhibit any cuts on their arms or legs that could imply that the candidate has self harmed?

Yes ☐ No ☐

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

_____

_____

_____

_____

6. Has the applicant, to the best of your knowledge, ever had a criminal conviction filed against them?

Yes ☐ No ☐

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

_____
_____
_____
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7. Does this applicant, to the best of your knowledge, have any history of physical, emotional or sexual abuse? Please note that the applicant will be caring for children and therefore it is important that this information is accurate.

Yes ☐ No ☐

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

_____
_____
_____
_____

Name of Doctor:	
Practice:	
Telephone number:	Fax:
Signature: Date:	Doctors stamp or seal of the practice

Information:

Please print a copy of this documentation and bring it to your medical practitioner. Please send the original to Au Pair Link Limited and make a copy for yourself.

Important Notice

The applicant has granted permission to Au Pair Link to conduct this medical check. This medical check contains both personal and professional information which is strictly confidential and may be legally privileged. Information in this reference check is intended for the named recipient only .If the reader is not the named recipient, you are duly notified that any use, disclosure, copying or distribution of this information is prohibited. The information in this reference check is to be used for the specified purpose only.

Failure to comply with these instructions may be a breach of the Privacy Act 1993.

Thank you for providing Au Pair Link Limited with a truthful and accurate portrayal of your medical history. We appreciate your co-operation.