# Medical (Either provide medical certificate from your doctor or ask this form to be completed and signed by your doctor) *This person is applying to be an au pair in Spain*

| | |
|---|---|
| Au pair name | |
| Date of birth | |

*Has the applicant suffered from/been treated for any of the following in the past 2 years:*

| | | | | | |
|---|---|---|---|---|---|
| Asthma | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Allergies | ☐ Yes | ☐ No |
| Nervous illness | ☐ Yes | ☐ No | Stress/Depression | ☐ Yes | ☐ No |
| Drug problems | ☐ Yes | ☐ No | Eating disorder | ☐ Yes | ☐ No |

Is the applicant taking medication? ☐ Yes ☐ No

Is the applicant pregnant? ☐ Yes ☐ No

Does the patient have any pre-existing medical conditions ☐ Yes ☐ No

If yes to any of the above, please give details:

Would you consider this person fit to work with children? ☐ Yes ☐ No

| | |
|---|---|
| Any comments | |

| | | |
|---|---|---|
| Physicians name | | Stamp |
| Phone number | | |
| Signature | | |
| Date | | *By giving your signature you give permission to be contacted.* |

**This section must be signed by the au pair applicant**

If my medical condition changes (including pregnancy), between the time of signing this document and my departure to Spain, I understand that I am required to notify ServiHogar and resubmit another medical form prior to my arrival. I also understand that failure to adhere to this policy may result in my termination of the program.
I accept responsibility for any medical expenses which are not covered by my insurance policy, and understand that pre-existing medical conditions will not be covered.
I also give my full consent to release this information to potential host families

| | | | |
|---|---|---|---|
| Au pair signature | | | |
| Print name | | Date | |

*Avda Santa Beatriz de Silva 34, 11500 El Puerto de Santa María, CÁDIZ- SPAIN*

TLF/FAX: 0034 956 85 1744 - info@servihogar.org