

Certificate of Health

Name : _____ Sex: ☐ Male ☐ Female
Date of Birth : _____ (yy/mm/dd) Age: _____

1. Physical Examination (身体検査)

Blood Type	A	B	O	AB	RH	+	-	Hearing	<input type="checkbox"/> normal	<input type="checkbox"/> impaired
Eyesight	glasses or contact lenses <input type="checkbox"/> necessary <input type="checkbox"/> unnecessary									

2. Allergies to Medicines (薬アレルギー): _____

Others (その他のアレルギー): _____

3. Chest (胸部) (Please describe the results of physical and X-ray examinations of the applicant's chest X-rays.)

* X-rays taken more than 6 months prior to this certification are NOT valid.

Lungs	<input type="checkbox"/> normal <input type="checkbox"/> impaired	Heart (心臓)	<input type="checkbox"/> normal <input type="checkbox"/> impaired
(肺)	Date of X-ray: () Film No.: () <input type="checkbox"/> Direct <input type="checkbox"/> Indirect	(If impaired,) describe the condition of applicant's chest: _____ _____	

4. Laboratory Tests (Urinalysis) (検尿): Glucose (糖) (), Protein (蛋白) (), Occult Blood (潜血) ()

5. Under Medical Treatment / Medical History (Diseases which may affect future health condition) (現在治療中の病気 / 既往歴)

<input type="checkbox"/> No <input type="checkbox"/> Yes	Disease (病気): _____	Age of onset (罹患年齢): _____
	Remarks (所見): _____	
	Disease (病気): _____	Age of onset (罹患年齢): _____
	Remarks (所見): _____	

(ex) Tuberculosis (結核), Heart Diseases (心臓病), Convulsions / Epilepsy (ひきつけ / てんかん), Diabetes (糖尿病), Malaria (マラリア),
Renal Disease (腎臓病), High Blood Pressure (高血圧), Asthma (ぜんそく), Anemia (貧血), Color-blindness (色盲), Irregular pulse (不整脈),
Functional Disorder in Extremities (四肢の機能障害)

6. General Remarks (Any additional information host university should be aware of) (総合的所見)

After reviewing the applicant's medical history and physical condition, I believe him / her to be in good physical and mental health, free of any chronic conditions, disorders or contagious diseases, and capable physically and mentally of completing two semesters of study in a Japanese university.

Date of Examination: _____ Signature: _____
Clinic/Hospital: _____
Address: _____
Doctor's Name: _____