CERTIFICATE OF HEALTH (to be completed by the examining physician)

Please fill out (PRINT/TYPE) in ENGLISH

Name: _____

Family name First name Middle name

Date of birth: _____ (MM/DD/YYYY) Age: _____ ☐Male ☐Female

1. Physical Examination

Height: _____ cm Weight: _____ kg

Blood pressure: _____ / _____ mmHg Pulse: ☐ regular ☐ irregular

Eyesight: R: _____ (_____) L: _____ (_____) (With glasses or contact lenses)

Hearing: ☐ normal ☐ impaired Speech: ☐ normal ☐ impaired

Lungs: ☐ normal ☐ impaired

Heart: ☐ normal ☐ impaired → Electrocardiograph: ☐ normal ☐ impaired _____

2. Chest X-ray examinations (Mandatory) (Record within 6 months of arrival in Japan):

Date: _____ (MM/DD/YYYY)

Findings: _____

_____

(An x-ray result is requested to confirm the presence of Tuberculosis and is mandatory for exchange student applications.)

3. Urinalysis: Glucose ( ) Protein ( ) Occult blood ( )

4. Under medical treatment at present: ☐ No

☐ Yes → Conditions/particulars: _____

5. Physical and / or learning disabilities: ☐ No

☐ Yes → Conditions/particulars: _____

6. Past medical history: Please indicate with (＋) or (—) .

Tuberculosis:	( )	Malaria:	( )	Other infectious disease:	( )
Epilepsy:	( )	Psychosis:	( )	Kidney disease:	( )
Heart disease:	( )	Lung disease:	( )	Gastrointestinal disease:	( )
Thyroid disease:	( )	Collagen disease:	( )	Diabetes mellitus:	( )
Drug allergy: ( )					

Others: _____

Signature or Clinic stamp REQUIRED:

_____ _____ (MM/DD/YYYY)

Name & Signature of Physician or Clinic stamp Date

_____ _____

Medical Institution Address

_____

City State / Province Country