

**CERTIFICATE OF HEALTH**

Name: , Sex (indicated on passport): Male / Female

Family name First name, Middle Name

Date of Birth: Age:

**Health Conditions 病気・身体状況**

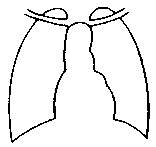
1. Please **TYPE** any health condition you feel is important for us to know, such as serious medical problem, physical disabilities, treatment history, etc.  
   治療中の疾病、身体障害、過去の治療歴や、健康上考慮してほしいことを記載してください。
2. If you are planning to bring medicine to Japan, please make a list (please **TYPE**).   
   また、日本に持ち込みたい薬がある場合は、記載してください。
3. After completing the above by applicant yourself, please print this form, consult your physician regarding items 1 and 2 above, and have them complete the following health form.  
   上記を出願者ご自身で記入後に、本紙を印刷し、1および２の事項を医師に相談し、以下の健康診断書を記載してもらってください。

--------------------- Next section should be completed by the examining physician ---------------------

\* Please complete all the necessary information that is in the next section. In case you have the additional medical documents, please submit them in English. If not in English, please submit a separate summary in English.

\*次のセクションについてすべての必要事項を記入ください。もし追加の診断書類がある場合は英語でご提出ください。英語でない場合は英語による概要説明を別途提出してください。

**Name: ,**



**Physical Examination ･ Laboratory Tests** \*Mandatory

\*【Height】: cm \*【Weight】: kg

\*【Blood Pressure】: mmHg ~ mmHg

\*【Urinalysis】: *Protein* ( ) *Glucose* ( ) *Occult Blood* ( )

\*【Eyesight】: *Right* ( ) *Left* ( ) *Right* ( ) *Left* ( )

*without glasses or contact lenses*  *with glasses or contact lenses*

\*【Hearing】: *Right* ( normal / impaired ) *Left* ( normal / impaired )

**2. Please describe the results of physical and X-ray examinations of the applicant’s chest x-rays .**

**All applicants are required to have X-ray examination taken within 6 months before the application deadline .**

\*Cardiomegaly \*Lungs

□ normal □ normal

□ impaired □ impaired

**↓**

Electrocardiograph \***Date of X-Ray (MANDATORY)**

□ normal Film No.  **↑**

□ impaired 　　　　　　　　　　　　 Describe the condition of applicant’s lungs.

\***3. Under medical treatment at present**

□ Yes (Name of illness: ) (Name of medication: )   
□ No

**4. Past history: Please indicate with A (recovered fully), B (receiving follow-up care) or C (under treatment at present). \*Please describe in CLEAR BLOCK format**

Name of illness / Medication **↓** Name of illness / Medication **↓**

Anemia/blood disease ( )( ) Tuberculosis ( )( )

Heart disease ( )( ) Kidney disease ( )( )

Thyroid disease ( )( ) Diabetes ( )( )

Asthma ( )( ) Epilepsy ( )( )

Psychosis ( )( ) Drug allergy ( )( )

Functional disorder in extremities ( ) ( )

Other medical problems or history of treatment ( )

**5. Particulars or additional comments: \*Please describe in CLEAR BLOCK format**

I hereby certify that the above information (Including information filled out by the student) is correct, and this student does not have any medical problems to study abroad.

Date: Physician's Print Name:

Address: Physician's Signature: