

Please print **NEATLY**
and **CLEARLY**

Certificate of Health

IMPORTANT NOTE

It is important that we be made aware of any medical or emotional problems which might affect you during your stay. The provided information will be treated as confidential and **will not affect your admission into the program**. However, depending on the findings, if the student is considered not to be in adequate mental and physical health for studying abroad, we may not be able to admit the student in some cases.

*This form must be completed by a medical physician. If you do not have antibodies against infectious diseases listed below, we strongly recommend that you get vaccinated.

Name	_____		
	Family	Given	Middle
Date of Birth	_____ Year	_____ Month	_____ Day
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Examination Report - Current State of Health

Eye-sight	(L) _____ (R) _____	<input type="checkbox"/> Without glasses or contact lenses <input type="checkbox"/> With glasses or contact lenses
Hearing	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired	
Chest X-ray	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired Date _____ Year Month Day	
	Describe the condition in detail.	
	※ Chest X-ray can be omitted if the results were negative for TB skin test(TST) or blood test(IGRA) taken within one year. Please indicate the date and results of the examination below	
	<input type="checkbox"/> TST <input type="checkbox"/> IGRA(QFT/T-SPOT) <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date _____ / _____ / _____ (Year) (Month) (Day)

Record of infectious diseases and immunization

Has the student ever had the following diseases and/or received vaccination?

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated	Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated
	Date of Recovery/Vaccination: _____ / _____ / _____		Date of Recovery/Vaccination: _____ / _____ / _____
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated	Varicella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated
	Date of Recovery/Vaccination: _____ / _____ / _____		Date of Recovery/Vaccination: _____ / _____ / _____

Medical conditions which might affect the student's academic performance

Has the student had any serious medical problems or chronic illnesses in the past? Yes No

If "Yes", please indicate the name of the disease and recovery date.
e.g. bronchial asthma, cardiac diseases, epilepsy, etc.

Are there any physical or mental conditions that may limit the student's ability to study? Yes No

If "Yes", please describe the conditions in detail.

Does the student have any food or drug allergies? If "Yes", please describe.

Do you consider the student to be in adequate mental and physical health to participate in the study abroad program? Yes (Adequate) No (Inadequate)

If "No", please describe the reason.

Official Stamp of Institution/Clinic	Date _____
	Institution/Clinic _____
	Address _____
	Name of Physician _____
	Signature _____