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

Please fill out (PRINT/TYPE) in English and mark ✓ in appropriate ☐ by a physician.

Name (Full spell): _____

☐Male ☐Female

Date of Birth: _____

Age: _____

1. Physical Examination

(1) Height: _____ cm Weight: _____ kg

(2) Blood pressure: _____ ～ _____ mm/Hg Pulse: ☐regular ☐irregular

(3) Eyesight: (R) _____ (L) _____ ☐without ☐With glasses or contact lenses

(4) Hearing: ☐normal ☐impaired

(5) Speech: ☐normal ☐impaired

(6) Lungs: ☐normal ☐impaired

(7) Heart: ☐normal ☐impaired → Electrocardiograph ( )

2. Chest X-ray examinations

Date _____ (within 3 months)

Describe the condition of applicant's lungs: ( )

3. Urinalysis : glucose ( ) protein ( ) occult blood ( )

4. Past history or present illness

☐ Tuberculosis	☐ Malaria	☐ Other infectious disease
☐ Epilepsy	☐ Psychosis	☐ Kidney disease
☐ Heart disease	☐ Lung disease	☐ Gastrointestinal disease
☐ Thyroid disease	☐ Collagen disease	☐ Diabetes mellitus
☐ Drug allergy	☐ Food allergy	

☐ Others ( )

5. Under medical treatment at present : ☐No ☐Yes

Conditions/particulars ( )

Physical disability : ☐No ☐Yes

Conditions/particulars ( )

6. Status of immunization

Indicate the date of vaccine, a physician documented history, or serologic evidence of immunity.

Varicella / Chicken pox : History of onset : Date of diagnosis ( )

Serum Antibody Titer : _____ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Rubella : History of onset : Date of diagnosis ( )

Serum Antibody Titer : _____ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Measles : History of onset : Date of diagnosis ( )

Serum Antibody Titer : _____ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Mumps : History of onset : Date of diagnosis ( )

Serum Antibody Titer : _____ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

[For students / researchers with field work activities]

Tetanus : Date of vaccination : Date ( ) (within 5 Years)

[For students / researchers with medical field activities]

Hepatitis B : Serum Antibody Titer : _____ (date)

Date of vaccination : Date 1 ( ) Date 2 ( ) Date 3 ( )

7. The applicant's health status is adequate to pursue studies in Japan.

☐ YES ☐ NO

8. Additional comments. If he/she needs special supports, please describe in detail.

Physician's Signature :_____Date : _____

Physician's Name (Print) : _____

Office/Institution : _____

Address : _____

Phone : _____ Fax : _____

E-mail address : _____