Please print NEATLY and CLEARLY

Certificate of Health

SAMPLE

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**	☐ Male ☐ Female

Examination Report・Current State of Health

Eye-sight	**[Blank or "- " will not be accepted]** (L)_____ (R)_____ ☐ Without glasses or contact lenses ☐ With glasses or contact lenses **[Make sure to tick]**
Hearing	☐ Normal ☐ Impaired
Chest X-ray	☐ Normal ☐ 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.** ☐ TST ☐ IGRA(QFT/T-SPOT) ☐ Negative ☐ Positive Date / / (Year) (Month) (Day)

Record of infectious diseases and immunization

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

[Tick one of the three options]

[The dates MUST be filled in]

Measles	☐ Yes ☐ No ☐ Vaccinated Date of Recovery/Vaccination: / /	**Rubella**	☐ Yes ☐ No ☐ Vaccinated Date of Recovery/Vaccination: / /
Mumps	☐ Yes ☐ No ☐ Vaccinated Date of Recovery/Vaccination: / /	**Varicella**	☐ Yes ☐ No ☐ Vaccinated 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 allegies? 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)

[MUST be ticked by the physician]

If "No", please describe the reason.

Official Stamp of Instition/Clinic

Date _____

Institution/Clinic _____

Address _____

Name of Physician _____

Signature _____