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									
rano	Family	Family Given		Middle					
Date of Bir		Month Day	Sex	☐ Male	☐ Female				
F		,							
Examination	n Report-Current State	or Health							
Eye-sight	(L)	☐ Without glasses or contact lenses (L) ☐ (R) ☐ With glasses or contact lenses							
Hearing	☐ Normal	☐ Impaired							
	☐ Normal	☐ Impaired	Date	Year	Month Day				
	Describe the condit	·:- /							
Chest X-ra	X Chest X-ray can be year.	Chest X-ray can be omitted if the results were negative for TB skin test(TST) or blood test(IGRA) taken within one year.							
	☐ TST	☐ IGRA(QFT/T-SPOT)	Date / /						
	☐ Negative	☐ Positive		(Year) (Month	(Day)				
Record of in	nfectious diseases and	immunization							
Has the student ever had the following diseases and/or received vaccination?									
	☐ Yes ☐ No	□ Vaccinated		☐ Yes ☐ No	☐ Vaccinated				
Measles	Date of Recovery/Vaccination	on: / /	Rubella	Date of Recovery/Vaccina	ation: / /				
	☐ Yes ☐ No	□ Vaccinated		☐ Yes ☐ No	☐ Vaccinated				
Mumps	Date of Recovery/Vaccination	on: / /	Varicella	Date of Recovery/Vaccina	ation: / /				
Medical conditions which might affect the student's academic performance Has the student had any serious medical problems or chronic illnesses in the past?									
Are there any physical or mental conditions that may limit the student's ability to study? If "Yes", please describe the conditions in detail.									
Does the student have any food or drug allegies? If "Yes", please describe.									
study abroad		adequate mental and phy	sical health t	o participate in the	☐ Yes (Adequate)☐ No (Inadequate)				
		Date							
		ng							
Officia	al Stamp of Instition/Clinic	Institution/Clinic Address							
		Name of Physician							
<u> </u>	Signature								

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.

,	37								
Name				- M-11					
Date of Bir	Family th	Given	Sex	Middle	☐ Female				
	•	Month Day				Ⅎ			
Examinatio	n Report-Current State		<u> </u>						
Eye-sight	[Blank or "- (L)	" will not be accepted (R)	_	ithout glasses or contac ith glasses or contact le	t lenses [Make sure to nses tick]				
Hearing	☐ Normal	☐ Impaired							
	□ Normal Describe the conditi	☐ Impaired	Date	Year	Month Day				
	December and communi	Describe the condition in detail.							
Chest X-ra	Chest A-ray can be	** 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.							
	□ тѕт	☐ IGRA(QFT/T-SPOT)	Data	1	1				
	☐ Negative	☐ Positive	Date	(Year) (Month)	/ (Day)				
Pacard of it	nfectious diseases and	immunization							
			nd vaccinatio	m?		F.Tiele en e ef 4			
has the stud		ng diseases and/or receive	ed vaccinatio		D Varainatad	[Tick one of three options			
Measles	☐ Yes ☐ No Date of Recovery/Vaccination		Rubella	☐ Yes ☐ No Date of Recovery/Vaccinati	on: / /	tillee options			
	☐ Yes ☐ No			☐ Yes ☐ No	□ Vaccinated	[The dates			
Mumps	Date of Recovery/Vaccination		Varicella	Date of Recovery/Vaccinati	on: / /	→ MUST be fille → in]			
Medical cor	nditions which might af	fect the student's acade	mic perform	ance		= ,			
			-		☐ Yes ☐ No	_			
Has the student had any serious medical problems or chronic illnesses in the past?									
Are there an	y physical or montal con	ditions that may limit the s	tudont's abil	ity to study?	П Усе П Ме	_			
	ease describe the condition		student 5 abii	ity to study?	☐ Yes ☐ No				
Does the student have any food or drug allegies? If "Yes", please describe.									
	·								
-		adequate mental and phy	sical health t	o participate in the	☐ Yes (Adequate)	[MUST be ticked by the			
study abroad program? No (Inadequate) If "No", please describe the reason.									
ii No , piease	e describe the reason.					physician]			
						\neg			
<u>Date</u>									
		Institution/Clinic							
Officia	al Stamp of Instition/Clinic	Address							
		Name of Physician							
<u> </u>		; Signature							