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 inadequate 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 measles, mumps, rubella, and varicella, 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	(L)_____ (R)_____	☐ Without glasses or contact lenses ☐ With glasses or contact lenses
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)

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)
If "No", please describe the reason.	

Official Stamp of Instition/Clinic

Date _____

Institution/Clinic _____

Address _____

Name of Physician _____

Signature _____