**健康診断書(GEPIS, GEP for R&D)** 　　**CERTIFICATE OF HEALTH (GEPIS, GEP for R&D )**

　　　　　　(医師に記入してもらうこと)　　　　　　　　　　　 (to be completed by the examining physician)

　　　　 日本語又は英語により明瞭に記載すること。　　　　　 Please fill out (PRINT/TYPE) in Japanese or English.

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| 氏 名  Name |  | |  |
| Surname 　姓　　　　　　　　　　Given name 名 | | Middle name 　ミドルネーム |
| 性別 □男 Male  Gender □女 Female | | 生年月日　　　　　　　　　　　　年　　　　月　　　　日  　　 Date of Birth yyyy mm dd | |

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| **1．身体検査**  **Physical examination** | | | | | | | | | | | | | | | | | | | | | | | | | |
| (1)身長  Height | | | | cm | | | | | | | | | | | (2)体重  Weight | | kg | | | | | | | | |
| (3)血圧  Blood pressure | | | | | | mmHg ～　　　　　mmHg | | | | | | | | | (4)血液型  Blood type | | | | □Ａ　□Ｂ　□ＡＢ　□Ｏ　□ＲＨ＋　□ＲＨ－ | | | | | | |
| (5)脈拍  　Pulse | | | □　整　Regular  　　　　　　　　□　不整　Irregular | | | | | | | | | | | | (7)色覚異常の有無  Color blindness | | | | | □　正常　Normal  　　　　　　　□　異常 Impaired | | | | | |
| (6)視力  Eyesight | | 裸眼　　　　 （右）　　（左）  Without glasses （Ｒ）　　（Ｌ） | | | | | | | | | | | | | (8)聴力  Hearing | | | | | □　正常　Normal  　　　　　　　□　異常 Impaired | | | | | |
| 矯正 (右)　　　(左)  With glasses or contact lenses (Ｒ)　　 　(Ｌ) | | | | | | | | | | | | | (9)言語  Speech | | | | | □　正常　Normal  　　　　　　　□　異常 Impaired | | | | | |
| **２．胸部聴聴及びＸ線検査**  **Physical and X-ray examination of the chest (within six months)** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | 胸部Ｘ線所見  Describe the condition of lungs. | | | | | 撮影年月日　　　　　　　　　年　　　　　月　　　　　日  Date of X-ray 　　 yyyy 　　　 mm 　　　　dd | | | | | | | | | |
|  | | | | | フィルム番号  Film No. | | | | | | | | | |
| (1)肺  Lungs | | | | | | | □　正常　Normal  □　異常 Impaired | | |
| (2)心臓  Cardiomegaly | | | | | | | □　正常　Normal  □　異常 Impaired | | |
| 異常がある場合⇒心電図  If impaired Electrocardiograph | | | | | | | □　正常　Normal  □　異常 Impaired | | |
| **３．現在治療中の病気**  **Disease currently being treated** | | | | | | | | | | | □　無　No 　　□　有 Yes　：　病名　Disease | | | | | | | | | | | | | | |
| **４．既往症**  **Past illness/disorder** | | | | | | | | | ✓ | | 病名　Name | | 完治時期/治療中  Date of recovery  /under treatment | | | | | | ✓ | | 病名　Name | | | | 完治時期/治療中  Date of recovery  /under treatment |
| 該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。  Please check and fill in the date of recovery/under treatment.  If NOT contracted any of them in the past, please check “None”. | | | | | | | | |  | | 結核  Tuberculosis | | | | | | | |  | | マラリア  Malaria | | | | |
|  | | その他感染症  Other communicable disease | | | | | | | |  | | てんかん  Epilepsy | | | | |
|  | | 腎疾患  Kidney disease | | | | | | | |  | | 心疾患  Heart disease | | | | |
|  | | 糖尿病  Diabetes | | | | | | | |  | | 薬剤アレルギー  Drug allergy | | | | |
| ✓ | 無し  None | | | | | | |  |  | | 精神疾患  Psychosis | | | | | | | |  | | 四肢機能障害  Functional disorder in the extremities | | | | |
| **５．検　査**  **Laboratory tests** | | | | | | | | | | | | | | | | | | | | | | | | | |
| (1)尿検査  Urinalysis: | | | | | 糖  glucose | |  | | | | | 蛋白  protein | |  | | | | | | | | 潜血  occult blood | |  | |
| (2)貧血検査  Anemia test | | | | | 赤沈  ESR | | mm/Hr | | | 白血球数  WBC count | | /cmm | | | | | | 血色素量  Hemoglobin | | | | gm/dl | | 貧血  Anemia | |
| (3)肝機能検査  LFT | | | | | GPT  (ALT) | | (IU/L) | | | | | GOT (AST) | | (IU/L) | | | | | | | | γ-GTP | | (IU/L) | |
| **６．医師の診断・意見**  **Physician’s impression of the applicant’s health**  継続的治療・投薬の必要性があればその旨ご記入ください。  Please fill in if the applicant needs regular medication or treatment. | | | | | | | | | | | |  | | | | | | | | | | | | | |

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| **７．In view of the applicant’s history and the above findings, is it your observation that his/her health status is adequate to**  **pursue studies in Japan? 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は充分に留学に耐えうるものと思われますか？** | 日付  Date |  |
| 医師署名  Physician’s Signature |  |
| **□** YES（はい）　 　　**□** NO（いいえ） | 検査施設名  Office/Institution |  |
| **※ Please be sure to check either “YES” or “NO”. If you do not check “YES”, the University will NOT accept the application. 必ず「はい」又は「いいえ」にチェックしてください。「はい」にチェックがない場合、大学は出願を受理しません。** | 所在地  Address |  |