

**CERTIFICATE OF HEALTH 健康診断証明書**

(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.

氏名 男 Male 生年月日 年齢  
 Name : \_\_\_\_\_ 女 Female Date of Birth: Age:  
 Family name First name, Middle name

1. 身体検査

Physical Examinations

- (1) 身長 \_\_\_\_\_ cm 体重 \_\_\_\_\_ kg  
 Height Weight
- (2) 血圧 \_\_\_\_\_ mm/Hg ~ \_\_\_\_\_ mm/Hg 血液型 

A B O	RH +
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 脈拍 整 regular 不整 irregular  
 Blood pressure Blood Type Pulse
- (3) 視力 色覚異常の有無 正常 normal 異常 impaired  
 Eyesight : (R) \_\_\_\_\_ (L) \_\_\_\_\_  
 (裸眼 without glasses) Color blindness
- (4) 聴力 正常 normal 言語 正常 normal 異常 impaired  
 Hearing : 異常 impaired Speech :

2. 申請者の胸部について、聴診とX線検査の結果を記入して下さい。X線検査の日付も記入すること（6ヶ月以上前の検査は無効）。  
 Please describe the results of physical and X-ray examinations of applicant's chest.  
 (X-ray taken more than 6 months prior to the certification is NOT valid).



肺 正常 normal 異常 impaired  
 Lung : 正常 normal 異常 impaired  
 心臓 正常 normal 異常 impaired  
 Cardiomegaly :

肺の状態についてのコメント Describe the condition of applicant's lung: ↓ 異常がある場合  
If the result shows impaired:

心電図 正常 normal 異常 impaired  
 Electrocardiograph :

3. 現在治療中の病気・アレルギー  Yes (Disease: \_\_\_\_\_ ) (Allergy: \_\_\_\_\_ )  
 Disease / allergy treated at Present  No

4. 既往歴 Past history : Please indicate with + or - and fill in the date of recovery

Tuberculosis .....  ( . . ) Malaria .....  ( . . ) Other communicable disease .....  ( . . )  
 Epilepsy .....  ( . . ) Kidney Disease .....  ( . . ) Heart Diseases .....  ( . . )  
 Diabetes .....  ( . . ) Drug Allergy .....  ( . . ) Psychosis .....  ( . . )  
 Functional disorder in extremities .....  ( . . )

5. 検査 Laboratory tests

検尿 Urinalysis : glucose ( \_\_\_\_\_ ), protein ( \_\_\_\_\_ ), occult blood ( \_\_\_\_\_ )  
 赤沈 ESR : \_\_\_\_\_ mm/Hr, WBC count \_\_\_\_\_ /cmm, 貧血   
 Anemia  
 Hemoglobin : \_\_\_\_\_ gm/dl, GPT :

6. 診断医の印象を述べて下さい。Please describe your impression.

7. 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十分に留学に耐えうるものと思われますか？

In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue intended study in Japan?

Yes  No

日付 \_\_\_\_\_ 署名 \_\_\_\_\_  
 Date : Signature :

医師氏名  
 Physician's Name in Print : \_\_\_\_\_

検査施設名  
 Office/Institution : \_\_\_\_\_

所在地  
 Address : \_\_\_\_\_