

CERTIFICATE OF HEALTH

(to be completed by the examining physician)

Please fill out the following in English.

Name: _____

Family Name

First Name

Middle name

Date of Birth (yyyy/mm/dd): _____ Male Female

1. Physical Examination

1.1 Height: _____ cm Weight: _____ kg

1.2 Blood pressure: _____ mm/Hg Blood Type

A	B	O

RH	+
	-

Pulse Regular Irregular

1.3 Eyesight: (R) _____ (L) _____ (R) _____ (L) _____ Color vision Normal Impaired
Without glasses With glasses

1.4 Hearing Normal Impaired Speech Normal Impaired

2. Disease currently being treated: Yes, _____ (Disease name) No

3. Medical history: Check any of the diseases suffered by the applicant in the past and fill in the date of recovery. If the applicant did not suffer from any of the diseases, check None.

- Tuberculosis _____ Malaria _____ Other communicable disease _____
 Epilepsy _____ Kidney disease _____ Heart disease _____
 Diabetes _____ Functional disorder in extremities _____
 Food allergy _____ Drug allergy _____ Asthma _____
 Mental disorder _____ Cancer _____
 None

4. Did the applicant had any other serious medical conditions or problems not listed in number 3?

Yes _____ (disease name and date of recovery) No

5. Please give your impression of the applicant's health.

6. In view of the applicant's medical history and the above findings, is the health condition of the applicant adequate to pursue a short-term study abroad?

Yes No

Date (yyyy/mm/dd): _____ Signature of Physician: _____

Physician's Name in Print: _____

Name of Office/Institution: _____

Address: _____