

健康診断書(医学部・医学部附属病院)
CERTIFICATE OF HEALTH for applicants to School of Medicine and University Hospital
(to be completed by the examining physician)

日本語また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 Name: _____, _____ Gender _____ 生年月日 Date of birth ____/____/____ age ____
Family name First name Middle name (D/M/Y)

1 身体検査 Physical Examinations

身長 Height _____ cm 体重 Weight _____ Kg 血圧 BP _____/____ mmHg 脈拍 Pulse ____/min 整 regular 不整 irregular 血液型 A B O RH + -
視力 Rt. ____/Lt. ____ Rt. ____/Lt. ____ 聴覚 正常 normal 異常 impaired 言語 正常 normal 異常 impaired
Eyesight 裸眼 (without glasses) 矯正 (with glasses)

2 既往症 Past History なし None あり Yes. If yes, please check and describe detail.

- Tuberculosis Malaria Other communicable disease Kidney disease Epilepsy
- Heart disease Diabetes Drug Allergy Psychiatric disease
- Functional disorder in extremities Others (Disease _____)

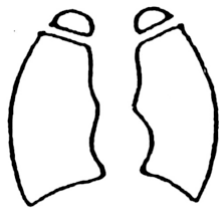
Detail:

3 現在治療中の病気 Diseases currently being treated 無 None 有 Yes

If yes, please describe detail:

4 胸部聴診およびX線写真(6か月以内) Chest physical and X-ray examination (**within 6 months***)

*If applicant have already checked chest Xp for VISA at institution authorized by Japanese government, attach copy of certification instead additional test.



Date ____/____/____ (D/M/Y)

Film No. _____

肺 Lung 正常 normal 異常 impaired → Describe the condition

心臓 Heart 正常 normal 異常 impaired → Describe the condition and check ECG

ECG 正常 normal 異常 impaired

5 検査 Laboratory tests

検尿 Urinalysis: glucose (), protein (), occult blood ()

血沈 ESR _____ mm/hr 白血球 WBC _____ /μL 血色素数 Hemoglobin _____ g/dl

肝機能 ALT _____ IU/L AST _____ IU/L γ-GT _____ IU/L

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6 予防接種 immunization history

(Applicants must receive the vaccinations of Measles, Mumps, Rubella, Varicella, and Hepatitis B, OR reveal positive serological results)

a. Measles, Mumps, Rubella (MMR)

First dose: ____/____/____ (D/M/Y), Second dose: ____/____/____ (D/M/Y)

Date of Serologic positive (if applicable)

Measles ____/____/____ Mumps ____/____/____ (D/M/Y) Rubella ____/____/____ (D/M/Y)

b. Varicella

First dose: ____/____/____ (D/M/Y), Second dose: ____/____/____ (D/M/Y)

Date of Serologic positive (if applicable) ____/____/____ (D/M/Y)

c. Hepatitis B (HBs antibody at least 1 month after completion of 3 consecutive doses of vaccination)

Date: ____/____/____ (D/M/Y), Titer and Result : _____ (Negative · Positive)

d. Tuberculosis (Baseline 1-step TB skin test (TST) within the last 6 months)

Date: ____/____/____ (D/M/Y), Induration and Result : ____ x ____ mm (Negative · Positive)

7 診断医の意見 Physician's impression of the applicant's health (継続的治療・投薬の必要性があれば、御記入ください
 Please fill in if the applicant needs regular medication or treatment.)

8 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日本への留学に耐え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 applicant's health status is adequate to pursue study/research in Japan? Yes, No

日付
Date ____/____/____
(D/M/Y)

署名
Signature: _____

医師氏名
Physician's name: _____

検査施設名
Office/ Institution: _____

所在地
Address: _____