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CERTIFICATE OF HEALTH

(Please print out and must be completed by the examining physician)

Name of examinee in Roman block capitals:

(Family name) _____ (Given name) _____ (Middle name) _____

Gender: ☐ Male ☐ Female

Date of Birth: Day: Month: Year: Age:

1. Physical Examinations

(1) Height _____ cm Weight _____ kg

(2) Blood pressure mm/Hg mm/Hg Blood Type Pulse | ABO | RH+ | RH- | ☐ Regular ☐ Irregular

(3) Eyesight : (R) _____ (L) _____ Color blindness ☐ Normal ☐ Impaired

(Without glass)

(4) Hearing: ☐ Normal ☐ Impaired Speech ☐ Normal ☐ Impaired

2. Please describe the results of physical and X-ray examinations of applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).

Lung: ☐ Normal ☐ Impaired Cardiomegaly: ☐ Normal ☐ Impaired

Describe the condition of applicant's lung. Electrocardiograph: ☐ Normal ☐ Impaired

3. Disease Treated at Present ☐ Yes (Disease: _____) ☐ No

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

☐ Tuberculosis (……) ☐ Malaria (……) ☐ Other communicable disease (……)
☐ Epilepsy (……) ☐ Kidney disease (……)
☐ Diabetes (……) ☐ Drug allergy (……) ☐ Heart disease (……)
☐ Functional disorder in extremities (……) ☐ Psychosis (……)

5. Laboratory tests

Urinalysis: Glucose _____ protein _____ occult blood
ESR: _____ mm/Hr, WBC count: _____ /cmm ☐ anemia _____

6. Please describe your impression: _____

7. In view of the applicant's history and the above findings, is it your observation his/her health status is adequate to pursue studies? ☐ Yes ☐ No

Date: ..... Signature: .....
Physician's Name in Print:

Office/Institution:	
Address:	