

Please refer to the information filled with red and prepare for the certificate which all the information is filled in.
If there are no appropriate information, please fill in "N/A" and do NOT keep the information blank.
Unless the applicant has special reasons, the applicant needs to submit the certificate which all the information are filled in.
If there are any parts which are difficult to be filled in for personal reasons, please attach the information letter on that issued by the doctor or home university.

Fill in all the part. Certificate with blank is not accepted.

健康診断書

(医師に記入してもらうこと)

日本語又は英語により明瞭に記載すること。

CERTIFICATE OF HEALTH

(to be completed by the examining physician)

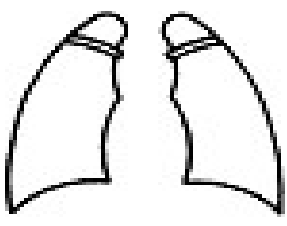
Please fill out (PRINT/TYPE) in Japanese or English.

SAMPLE

氏名 Name	Gaidai	Surname 姓	Hanako	Given name 名	Middle name ミドルネーム
性別 Gender	<input type="checkbox"/> 男 Male <input checked="" type="checkbox"/> 女 Female	生年月日 Date of Birth	20XX 年 X 月 X 日 yyyy mm dd		

1. 身体検査 Physical examination			
(1)身長 Height	XXX cm	(2)体重 Weight	XXX kg
(3)血圧 Blood pressure	XXX mmHg ~ XXX mmHg	(4)血液型 Blood type	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input checked="" type="checkbox"/> RH + <input type="checkbox"/> RH -
(5)脈拍 Pulse	<input checked="" type="checkbox"/> 整 Regular <input type="checkbox"/> 不整 Irregular	(7)色覚異常の有無 Color blindness	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
(6)視力 Eyesight	裸眼 (右) (左) Without glasses (R) XX (L) XX 矯正 (右) (左) With glasses or contact lenses (R) (L)	(8)聴力 Hearing	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		(9)言語 Speech	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired

Please be sure to be tested after September 2024.

2. 胸部聴診及びX線検査 (6か月以内) Physical and X-ray examinations of the chest (within six months)			
	胸部X線所見 Describe the condition of lungs.	撮影年月日 Date of X-ray	20XX 年 XX 月 XX 日 yyyy mm dd
	normal	フィルム番号 Film No.	1234567890
		(1)肺 Lungs	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
		(2)心臓 Cardiomegaly	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired
	異常がある場合⇒心電図 If impaired⇒Electrocardiograph	<input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired	

If no film. No. is issued, please fill in "N/A"

3. 現在治療中の病気 Disease currently being treated		<input checked="" type="checkbox"/> 無 No <input type="checkbox"/> 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
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
		その他感染症 Other communicable disease
		腎疾患 Kidney disease
		糖尿病 Diabetes
		精神疾患 Psychosis
	無し None	マラリア Malaria
		てんかん Epilepsy
		心疾患 Heart disease
		薬剤アレルギー Drug allergy
		四肢機能障害 Functional disorder in the extremities

If the applicant has no past illness/d isorder, please check here.

If the result is negative, please fill in "negative".

5. 検査 Laboratory tests							
(1)尿検査 Urinalysis:	糖 glucose	negative	蛋白 protein	negative	潜血 occult blood	negative	
(2)貧血検査 Anemia test	赤沈 ESR	XX mm/Hr	白血球数 WBC count	XX /cmm	血色素量 Hemoglobin	XX gm/dl	
(3)肝機能検査 LFT	GPT (ALT)	XX (IU/ l)	GOT (AST)	XX (IU/ l)	γ-GTP	XX (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下さい。 Please fill in if the applicant needs regular medication or treatment.	No needs regular medication or treatment.
---	---

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十分に留学に耐えうるものと思えますか？	日付 Date	20XX/ XX/ XX
<input checked="" type="checkbox"/> YES (はい) <input type="checkbox"/> NO (いいえ) ※Please be sure to check either "YES" or "NO". If you do not check "YES", the application will NOT be accepted. 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、申請を受理しません。	医師署名 Physician's Signature	XXXXXXXXXXXXX
	検査施設名 Office/Institution	XXXXXXXXXXXXX
	所在地 Address	XXXXXXXXXXXXX

Please be sure to be issued after September 2024.

Please be sure to be checked in "YES".
If it is checked in "NO", TUFs does not accept the application.