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.

SAMPLE

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 the form either typing or writing in block letters in Japanese or English.

氏名 Name	Gaidai Surname 姓	Hanako Given name 名	Middle name ミドルネーム
性別 Gender	☐ 男 Male ☑ 女 Female	生年月日 Date of Birth	20XX 年 X 月 X 日 yyyy mm dd

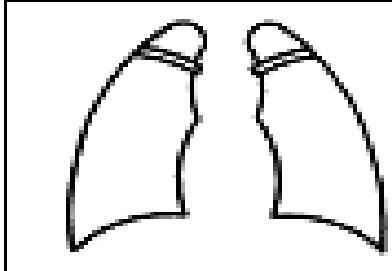
For "XX", please provide numerical answers.
Answers other than numerical values, such as "N/A" or "Normal", will not be accepted.

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	☑ A ☐B ☐AB ☐O ☑RH＋ ☐RH－
(5)脈拍 Pulse	☑ 整 Regular ☐ 不整 Irregular	(7)色覚異常の有無 Color blindness	☑ 正常 Normal ☐ 異常 Impaired
(6) 視力 Eyesight 裸眼 Without glasses	(右) (R) XX	(左) (L) XX	(8)聴力 Hearing ☑ 正常 Normal ☐ 異常 Impaired
矯正 With glasses or contact lenses	(右) (R)	(左) (L)	(9)言語 Speech ☑ 正常 Normal ☐ 異常 Impaired

Please be sure to be tested after April 2025.

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.	normal
撮影年月日 Date of X-ray	20XX 年 XX 月 XX 日 yyyy mm dd
フィルム番号 Film No.	1234567890
(1)肺 Lungs	☑ 正常 Normal ☐ 異常 Impaired
(2)心臓 Cardiomegaly	☑ 正常 Normal ☐ 異常 Impaired
異常がある場合⇒心電図 If impaired⇒Electrocardiograph	☑ 正常 Normal ☐ 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

☑ 無 No ☐ 有 Yes ： 病名 Disease

4．既往症 Past illness/disorder

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".

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

	✓	病名Name	完治時期/治療中 Date of recovery /under treatment	✓	病名Name	完治時期/治療中 Date of recovery /under treatment
✓	✓ 無し None	結核 Tuberculosis			マラリア Malaria	
		その他感染症 Other communicable disease			てんかん Epilepsy	
		腎疾患 Kidney disease			心疾患 Heart disease	
		糖尿病 Diabetes			薬剤アレルギー Drug allergy	
		精神疾患 Psychosis			四肢機能障害 Functional disorder in the extremities	

5．検 査 Laboratory tests

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

(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	貧血 Anemia negative
(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 need for 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充分に留学に耐えうるものと思われますか？

☑ YES （はい） ☐ NO （いいえ）

※Please be sure to check either "YES" or "NO". If you check "YES", the application will be accepted.
必ず「はい」又は「いいえ」にチェックしてください。「はい」にチェックした場合のみ受理します。

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

日付 Date	20XX/ XX/ XX
医師署名 Physician's Signature	●●●●●●●
検査施設名 Office/Institution	●●●●●●●
住所 Address	●●●●●●●

Please be sure to be issued after April 2025.