

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.

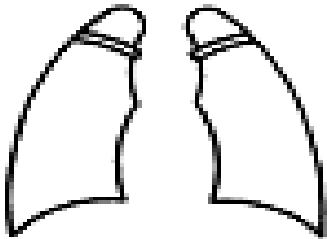
健康診断書
(医師に記入してもらうこと)
日本語又は英語により明瞭に記載すること。

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.

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 |

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|---------------------------------|--|--|--|
| 1. 身体検査 Physical examination | | For "XX", please provide numerical answers. Answers other than numerical values, such as "N/A" or "Normal", will not be accepted. | |
| (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 | (8)聴力 Hearing | <input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |
| | 矯正 (右) (左) With glasses or contact lenses (R) (L) | (9)言語 Speech | <input checked="" type="checkbox"/> 正常 Normal <input type="checkbox"/> 異常 Impaired |

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| 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 | |

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|---|-------------------------------------|--|---|---|--|---|
| 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 | ✓ | 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 | | | 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 | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 無し None | | | 四肢機能障害 Functional disorder in the extremities | |

| | | | | | | | |
|---------------------------|--------------|-------------|-------------------|-------------|--------------------|-------------|--------------|
| 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 | 貧血 Anemia |
| (3)肝機能検査 LFT | GPT (ALT) | XX (IU/ l) | GOT (AST) | XX (IU/ l) | γ-GTP | XX (IU/ l) | negative |

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| 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. |
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| 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るものと思われませんか? <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 check "YES", the application will be accepted. If you check "NO", TUFS does not accept the application. 必ず「はい」又は「いいえ」にチェックしてください。それ以外に記入した場合は、申請書は受理しません。 | 日付 Date | 20XX/ XX/ XX | |
| | 医師署名 Physician's Signature | ●●●●●●●● | |
| | 検査施設名 Office/Institution | ●●●●●●●● | |
| | 医師印 Physician's Seal | ●●●●●●●● | |