様式第5-B号（第2条第1項第5号及び第14条第2項第3号関係）

CERTIFICATE OF HEALTH

Name of Applicant (in Roman block capitals) _____

Sex (M ・ F) Age _____ Date of Birth ____ - ____ - ____

Present Address _____

Height _____ (cm) Weight _____ (kg)

1. SENSE SYSTEM

Eye Sight Right _____ (_____)

Left _____ (_____)

Color Blindness Normal / Abnormal

Hearing Normal / Abnormal

2. RESPIRATORY SYSTEM

Medical Judgment Normal / Abnormal

Chest X-Ray Examination

Condition of Applicant's Lungs

Normal / Abnormal

Film No. _____

3. CIRCULATORY SYSTEM

Medical Judgment Normal / Abnormal

(Heart Murmur Normal / Abnormal)

Blood Pressure sys. _____ / _____ dia.

Condition of Applicant's Heart

(cf. Above Graph)

Normal / Doubtful / Abnormal

4. URINE TEST

Sugar _____ Protein _____

(please indicate with ＋, if you find any disease or abnormality, or with －, if not)

5. BLOOD TEST

Blood Type: _____

ESR (Erythrocyte Sedimentation Rate)

1 hour later: _____ mm

2 hours later: _____ mm

GOT (AST) : _____ unit

GPT (ALT) : _____ unit

6. DECAYED TOOTH

Untreated _____ Treated _____

7. Allergy, if any

( ) No / ( ) Yes

What is applicant allergic to? ( )

8. Previous History

9. Total Judgment for Applicant's Health

Name & Title of Physician _____

Address _____

Date ____ - ____ - 20____ Signature _____