様式第３号（第２条関係）

健康診断書

CERTIFICATE OF HEALTH（to be completed by the examining physician）

日本語又は英語により明瞭に記載すること。
Please fill out (PRINT/TYPE) in Japanese or English. Do not leave any items blank.

氏名
Name：
Family name, First name Middle name

□男 Male
□女 Female
□その他 Non-binary

生年月日
Date of Birth：

年齢
Age：

1．身体検査 Physical Examinations

⑴ 身 長 Height_____cm 体 重 Weight_____kg

⑵ 血 圧 Blood pressure_____mm/Hg～_____mm/Hg

血液型 Blood Type

ＡＢＯ	RH ＋ －

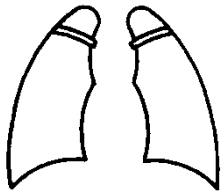
脈拍数 Pulse Rate _____/min □整 regular □不整 irregular

⑶ 視 力 Eyesight：(R)_____(L)_____ 裸眼 without glasses
(R)_____(L)_____ 矯正 with glasses or contact lenses

⑷ 聴 力 Hearing： □正常 normal □低下 impaired
言 語 speech： □正常 normal □異常 impaired

⑸ 色覚異常の有無 Color blindness： □正常 normal □異常 impaired

2．申請者の胸部について，聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査は無効。）
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).



肺
lung: □正常 normal □異常 impaired

Date_____

Film No._____

心臓
Cardiomegaly: □正常 normal □異常 impaired

心電図
Electrocardiograph
□正常 normal □異常 impaired

胸部聴診(呼吸音) Chest auscultation (breath sound)
□正常 normal □異常 impaired
Examinations of the neck (inspection, palpation)
□正常 normal □異常 impaired

Describe the condition of applicant's lung._____

3．現在治療中の病気 Disease & Treatment at Present □Yes (Disease:_____ Medicine:_____) □No

4．既往症 Past history : Please indicate with ＋ or － and fill in the date of recovery.
Tuberculosis……□(. .) Malaria……□(. .) Measles……□(. .)
Epilepsy……□(. .) Kidney disease……□(. .) Heart diseases……□(. .)
Diabetes……□(. .) Drug allergy……□(. .) Psychosis……□(. .)
Functional disorder in extremities……□(. .) Others……□(. .)
Rheumatic fever……□(. .) Hepatitis……□(Type: A, B, C, D, E) (. .)
Immunodeficiency(HIV, Chronic Kidney Failure, a Malignant Tumor) □(. .)
Immunosuppressant(Adrenocorticosteroid, Anticancer, Anti rheumatic drug)……□(. .)

5．ワクチン接種歴 Vaccination history
MMRV (Measles, Mumps. Rubella, Zoster)……□ Time(s) ( ) Mumps……□ Time(s) ( ) Hepatitis B……□ Time(s) ( )
MMR (Measles, Mumps. Rubella)……□ Time(s) ( ) Chicken pox……□ Time(s) ( ) Meningitis……□ Time(s) ( )
MR (Measles, Rubella)……□ Time(s) ( ) Polio……□ Time(s) ( )
M (Measles)……□ Time(s) ( ) Diphtheria Pertussis Tetanus combined……□ Time(s) ( )

6．検 査 Laboratory tests
検 尿 Urinalysis:glucose( ), protein ( ), occult blood ( )・検 便 Feces: Parasite(egg of parasite)(+,－)
赤沈 ESR：_____mm/Hr, WBC count：_____x10^3/μl, Hemoglobin:_____g/dl, ALT:_____u/l
貧血検査 Anemia Test: ESR：_____mm/Hr, WBC count：_____/cmm, Hemoglobin:_____gm/dl, Anemia:_____,
肝機能検査 LFT：GPT/ALT：_____(IU/L), GOT/AST：_____(IU/L), γ-GTP：_____(IU/L),

7．診断医の印象を述べて下さい。 Please describe your impression.
継続的治療・投薬の必要性があればその旨ご記入ください。Please fill in if applicant needs regular medication or treatment.

8．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？
In view of the applicant's history and the above findings, is it your observation his/her health status is adequate to pursue studies in Japan？ yes □ no □

日付
Date:

署名
Signature:

医　師　氏　名
Physician's Name in Print:

検査施設名
Office/Institution:

所在地
Address: