

CERTIFICATE OF HEALTH 健康診断書 【This form has to be filled out by a physician.】

Name of Applicant: 申請者氏名:	Sex 性別 M. 男 F. 女	Age 歳	Date of Birth 生年月日: / /
Present Address: 現住所:			Blood Type 血液型: A B O AB (Rh + -)
Dietary Restrictions due to Religious or Physical Reasons: 宗教的又は身体的理由で制限すべき食べもの:			

Height 身長	cm	Weight 体重	kg
Blood Pressure 血圧 Sys. ____/Dia. ____ mmHg		Pulse Rate 脈拍数 /m	☐ Reg. 整脈 ☐ Irreg. 不整脈
Reflexes 反射	Pupil 瞳孔: ☐ Normal, ☐ Abnormal Knee 膝: ☐ Normal, ☐ Abnormal Others 他(): ☐ Normal, ☐ Abnormal		
Eyesight 視力: without glasses ____ / ____ (with glasses 矯正) () / ()	Color-Blindness 色盲: Yes () No	Hearing 聴力: Left 左 : ____ Right 右 : ____	

1. Anamnesis 既往症:

(Indicate with “+”, if you find any disease or abnormality, or with “-”, if not.)

Tuberculosis 結核	Malaria マラリア	Other Communicable Diseases 他の伝染病
Rheumatism リウマチ	Liver Disease 肝臓病	Epilepsy てんかん
Asthma ぜんそく	Cardiac Disease 心臓病	Allergy アレルギー
Diabetes 糖尿病	Kidney Disease 腎臓病	Nervous or Mental Disorder 精神の障害

2. Present Conditions 現在の体調: (“+”, for any disease or abnormality, “-”, if not any.)

Skin 皮膚	Venereal Disease 性病	Pregnancy 妊娠
Stomach or Digestive System 胃・消化器系	Lungs or Respiratory System 肺・呼吸器系	Bones, Joints or Locomotor System 骨・関節・運動系
Tonsils, Nose or Throat のど・鼻	Genitourinary System 泌尿器系	Other Abdominal Organs その他 内臓
Heart or Blood Vessels 心臓・血管	Brain or Nervous System 脳・神経系	Blood or Endocrine System 血液・内分泌系
Nervous or Mental Disorder 精神の障害		

3. If you marked “+” to any of the above 1& 2, please describe each disease in detail (please use the back side of this sheet), and if the applicant is physically handicapped, describe the abnormality or impairment. 上記 1・2 で “+” がある場合には各症状の詳細を、また、申請者に身体障害がある場合、その部位・程度について、この紙の裏面にご記入ください。

4. Chest X-ray examination 胸部X線検査:

DATE of the examination 検査日 / / (Day/Month/Year)	conditions of applicant's lungs 胸部の状態 ☐ Normal, ☐ Abnormal ()
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5. The applicant's health, physical and mental conditions are:

(Please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

6. Is the applicant physically and mentally fit to go abroad for study and travel?

(Please check) ☐ Yes ☐ No

NAME & TITLE OF PHYSICIAN (*Please print)

ADDRESS

SIGNATURE

DATE (Day/Month/Year) / /

* 関西国際センターで裏面も含め本書を詳しく確認し、追加質問が生じた場合は改めてご連絡いたします。
 In case the Japan Foundation Japanese Language Institute, Kansai has any additional question on this sheet, officer in charge of your country would contact the applicant or the doctor.

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If the applicant has any allergy or any anamnesis; アレルギーや既往症がある場合;

- Will the applicant bring medicines for emergency? 申請者は薬を持参しますか?

☐ Yes (_____) ☐ No

- Which medical department do we need to take him/her, in case allergic reaction occurs?
(In this case it is NOT covered by our overseas travel insurance.)

アレルギー反応があったときは、何科を受診したらよいですか?

(既往症は海外旅行保険の対象外です)

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- First aid / dealing in case of emergency (if any); 急な発症の際の応急処置・対処法;

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- Any notice or advice for safe stay in Japan; 安全な日本滞在のための留意点・アドバイス;
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