All of the student must fill in this page!

Confidential

Medical checkup (Can be filled by the student)
※The certificate is valid for six months after getting it.

Date / /

Examination No.	Name		Sex
	Birthday	/ / (Age)	1. Male 2. Female

Your medical history

Name of Disease	Affected Area (Do you have?)	Present condition	Age of onset
1. Congenital heart disease	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
2. Arrhythmia	No / Yes	1.Cured 2.Under Treatment 4.Untreated	
3. Cardiac noise	No / Yes	1.Cured 2.Under Treatment 5.Untreated	
4. High-blood pressure	No / Yes	1.Cured 2.Under Treatment 6.Untreated	
5. Thyroid disease	No / Yes	1.Cured 2.Under Treatment 7.Untreated	
6. Stomach / Duodenum ulcer	No / Yes	1.Cured 2.Under Treatment 8.Untreated	
7 ulcerous colitis	No / Yes	1.Cured 2.Under Treatment 9.Untreated	
8. Nephritis	No / Yes	1.Cured 2.Under Treatment 10.Untreated	
9. Nephrosis	No / Yes	1.Cured 2.Under Treatment 11.Untreated	
10. Kidney / Urinary calculus	No / Yes	1.Cured 2.Under Treatment 12.Untreated	
11. Liver disease	No / Yes	1.Cured 2.Under Treatment 13.Untreated	
12. Diabetes	No / Yes	1.Cured 2.Under Treatment 14.Untreated	
13. Spontaneous pneumothorax	No / Yes	1.Cured 2.Under Treatment 15.Untreated	
14. Asthma	No / Yes	1.Cured 2.Under Treatment 16.Untreated	
15. Lung tuberculosis	No / Yes	1.Cured 2.Under Treatment 17.Untreated	
16. Epilepsy	No / Yes	1.Cured 2.Under Treatment 18.Untreated	
17. Mental disease	No / Yes	1.Cured 2.Under Treatment 19.Untreated	
18. Hyperventilation syndrome	No / Yes	1.Cured 2.Under Treatment 20.Untreated	
19. Food allergy	No / Yes	1.Cured 2.Under Treatment 21.Untreated	
20. Drug allergy	No / Yes	1.Cured 2.Under Treatment 22.Untreated	
21. Hearing disorder	No / Yes	1.Cured 2.Under Treatment 23.Untreated	
22. Vision disorder	No / Yes	1.Cured 2.Under Treatment 24.Untreated	
23. Limbs disorder	No / Yes	1.Cured 2.Under Treatment 25.Untreated	
24. Developmental disability	No / Yes	1.Cured 2.Under Treatment 26.Untreated	
25. Measles	No / Yes	1.Cured 2.Under Treatment 27.Untreated	
26. Rubella	No / Yes	1.Cured 2.Under Treatment 28.Untreated	
27. Mumps	No / Yes	1.Cured 2.Under Treatment 29.Untreated	
28. Chickenpox	No / Yes	1.Cured 2.Under Treatment 30.Untreated	
29. Others	No / Yes	1.Cured 2.Under Treatment 31.Untreated	

→ If Yes, fill in the disease name you have/had ( )

Immunization Record

Have you got the vacicinations named below?		
MMR (Measles, Mumps, Rubella)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
MR (Measles, Rubella) (1st dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
MR (Measles, Rubella) (2nd dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
Measles (1st dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
Measles (2nd dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
Rubella (1st dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
Rubella (2nd dose)	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	
Mumps	Yes	No
	If yes, list the date ↓ / / Date/ Month /Year	
Chicken-pox	Yes	No
	If yes, fill in the date ↓ / / Date/ Month /Year	

Blood type:

O / A / B / AB (+) (-)

Do you have a physical disability certificate?
Yes / No

If your program duration is less than 90days, you don't need to complete this page.

If your program length is more than 90days, Complete this health examination form by your doctor.

CERTIFICATE OF HEALTH

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.

氏名
Name: _____ , _____
Family name, First name Middle name

☐ 男 Male
☐ 女 Female

生年月日 Date of Birth:

年齢 Age:

1. 身体検査 (Physical Examination)

(1)身 長 Height: cm
体 重 Weight: kg
血液型 Blood type
脈 拍
☐ 整 regular Pulse
☐ 不 整 irregular

(2)血 圧 Blood pressure
mm/Hg ～ mm/Hg
A, B, O, AB
+ RH -

(3) 視 力 Eyesight:
(R) (L) 裸眼 Without glasses or contact lenses
(R) (L) 矯正 With glasses or contact lenses
色覚異常の有無 Color blindness
☐正常 normal
☐異常 impaired

(4) 聴 力 Hearing:
☐正常 normal
☐低下 impaired

言 語 Speech:
☐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 the applicant's chest x-rays (X-rays taken more than 6 months ago is invalid)

必須 Mandatory

肺 Lungs:
☐正常 normal
☐異常 impaired

Describe the condition of applicant's lungs

Date _____
Film no: _____
(In case of inquiry)

心臓 Cardiomegaly:
☐正常 normal
☐ 異 常 impaired

If impaired, Please take the Electrocardiograph(心電図)
☐正常 normal
☐ 異 常 impairedn

3. 現在治療中の病気
Under medical treatment at present
☐Yes (Conditions/particulars:
☐No

4. 既往症
Past history : Please indicate with ＋ or － and fill in the date ofrecovery for (. .). *If you have

Tuberculosis(肺結核).....☐(. .)
Epilepsy(てんかん).....☐(. .)
Diabetes(糖尿病).....☐(. .)
Functional disorder in extremities(四肢の機能障害).....☐(. .)
Malaria(マラリア).....☐(. .) Other communicable disease(その他の伝染病).....☐(. .)
Kidney disease(腎臓病).....☐(. .) Heart disease(心臓病).....☐(. .)
Drug allergy(薬剤アレルギー).....☐(. .) Psychosis(精神病).....☐(. .)

5. 検 査 Laboratory tests
検 尿 Urinalysis: glucose ( ), protein ( ), occult blood ( )
赤沈 ESR:_____mm/Hr, WBC count:_____/cmm
Hemoglobin:_____g/dl, GPT: _____
貧 血 ☐ anemia

6. 現在服用中の薬（薬剤名・処方量）について
☐ No medications, If the applicant is under a condition that requires continued monitoring, please give the details.

7. 過去5年間に精神科医またはカウンセラーに治療や相談はしたことはありますか？ある場合は内容を記入。
Have the applicant been under the care of a psychiatrist and/or counselor in the past 5 years? If yes, please explain.
No ☐ , Yes☐ If yes, Please explain:

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, do you think his/her health status is adequate to pursue studies in Japan?
☐ Yes, the applicant CAN participate in
☐ No, you can NOT participate in. If "No", Please describe the reasons

If the above answer is "No" implying that the applicant is not adequate to pursue studies in Japan, please consult the international office at SIT.

日付:
Date: _____

署名
Signature: _____

医師氏名
Physician's Name (Print): _____

検査施設名 Office/Institution:
所在地 Address: _____