CERTIFICATE OF HEALTH

(to be completed by the examining physician)

Please fill out the following in English.

Name: _____ _____ _____

Family Name First Name Middle name

Date of Birth (yyyy/mm/dd): _____ ☐ Male ☐ Female

1. Physical Examination

1.1 Height: _____cm Weight: _____kg

1.2 Blood pressure: _____ mm/Hg Blood Type | A B O | RH +/−

Pulse ☐ Regular ☐ Irregular

1.3 Eyesight: (R)_____ (L)_____ (R)_____(L)_____ Color vision ☐ Normal ☐ Impaired

Without glasses With glasses

1.4 Hearing ☐ Normal ☐ Impaired Speech ☐ Normal ☐ Impaired

2. Disease currently being treated: ☐ Yes, _____(Disease name) ☐ No

3. Medical history: Check any of the diseases suffered by the applicant in the past and fill in the date of recovery. If the applicant did not suffer from any of the diseases, check None.

☐ Tuberculosis _____ ☐ Malaria_____ ☐ Other communicable disease _____

☐ Epilepsy_____ ☐ Kidney disease_____ ☐ Heart disease_____

☐ Diabetes_____ ☐ Functional disorder in extremities _____

☐ Food allergy_____ ☐ Drug allergy_____ ☐ Asthma_____

☐ Mental disorder_____ ☐ Cancer_____

☐ None

4. Did the applicant had any other serious medical conditions or problems not listed in number 3?

☐ Yes_____ (disease name and date of recovery) ☐ No

5. Please give your impression of the applicant's health.

6. In view of the applicant's medical history and the above findings, is the health condition of the applicant adequate to pursue a short-term study abroad?

☐ Yes ☐ No

Date (yyyy/mm/dd):_____ Signature of Physician:_____

Physician's Name in Print:_____

Name of Office/Institution:_____

Address:_____