関西大学　健康診断証明書

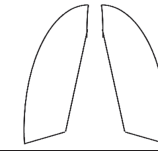
Kansai University Certificate of Health

To be completed in English by the examining physician.

Name				Date of birth (yyyy/mm/dd)	Age
Family	First	Middle (if applicable)	☐ Male ☐ Female	/ /	

Physical Examinations							
Height	cm	Weight	kg	Blood type	☐ A ☐ B ☐ O ☐ AB	Rh/	☐ + ☐ −
Hearing	☐ Normal ☐ Impaired	Eyesight	(R) (L) ☐ with glasses or contact lenses ☐ without glasses				

X-ray Examination (Must have been taken within 6 months.)					
Lung	☐ Normal ☐ Impaired	Cardiomegaly	☐ Normal ☐ Impaired	Electrocardiogram (in case of cardiomegaly)	☐ Normal ☐ Impaired
Describe the condition of applicant's lung.	Date (yyyy/mm/dd): / /				



Past History		
Please check the following box if there is any relevant disease and fill in the date (yyyy/mm/dd) of recovery.		
☐ Tuberculosis (/ /)	☐ Malaria (/ /)	☐ Other Communicable Disease (/ /)
☐ Epilepsy (/ /)	☐ Kidney Disease (/ /)	☐ Heart Disease (/ /)
☐ Diabetes (/ /)	☐ Drug Allergy (/ /)	☐ Psychological Disorder (/ /)
☐ Functional Disorder in Extremities (/ /)		☐ Others (disease:)
Disease treated at present		☐ Yes (disease:) ☐ No
If yes, will you continue taking medication or treatment during your stay in Japan?		☐ Yes ☐ No
If yes, please provide detailed information regarding the medication or treatment you have been taking and please attach the document including medical information.		Type of medication/treatment: ( ) Frequency: ( ) times (per week・per day)
Physician's comment		
In view of his/her medical history and above findings, is it your observation his/her health status is adequate to pursue studies in Japan?		☐ Yes ☐ No

Date (yyyy/mm/dd): / /

Physician's signature:

Physician's name in print:

Name of the office/institution:

Address of the office/institution: