

For International Students/Researchers

University is providing a healthy and safe campus according to the School Health and Safety Act and the Occupational Health and Safety Act. For infection control and accommodation services, we require all participants to provide individual health information.

Please submit attached CERTIFICATE OF HEALTH completed by a physician, and issued by a medical institute.

Notice:

1. If you require special support or accommodation, please describe in detail.
2. Measles, rubella, mumps, and chicken pox are highly contagious. To prevent outbreaks on campus, all of the population must have adequate levels of immuno-defense power (antibody titers) for each infectious disease. If you have a previous history of infection or vaccination, please fill out the onset date or date of the shot. If you have no idea, measure your antibody titer with blood analysis and fill out the form attached. If the titer is insufficient, please have an additional vaccination and fill out the vaccination information.

The Health Administration Center is a support center provided to ensure a comfortable life at the university. The center provides first aid and health promotion, as well as consultations for physical and mental concerns. If you have any worries or concerns, please do not hesitate to contact us.

Personal health information is never distributed outside the Health Administration Center without your permission, except in a life-threatening emergency. Your health information will be used only for the purpose of health support and administration. You will never experience any disadvantages related to providing the health information.

University Health Administration Center,

E-mail:

TEL:

URL:

FAX:

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

Please fill out (PRINT/TYPE) in English and mark ✓ in appropriate by a physician.

Name (Full spell): _____

Male Female

Date of Birth: _____

Age: _____

1. Physical Examination

(1) Height: _____ cm Weight: _____ kg

(2) Blood pressure: _____ ~ _____ mm/Hg Pulse: regular irregular

(3) Eyesight: (R) _____ (L) _____ without With glasses or contact lenses

(4) Hearing: normal impaired

(5) Speech: normal impaired

(6) L u n g s: normal impaired

(7) H e a r t: normal impaired → Electrocardiograph (_____)

2. Chest X-ray examinations (Record within 6 months)



Date _____

Describe the condition of applicant's lungs: (_____)

3. Urinalysis : glucose () protein () occult blood ()

4. Past history or present illness

- | | | |
|---|---|---|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Other infectious disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Gastrointestinal disease |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Collagen disease | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Drug allergy | <input type="checkbox"/> Food allergy | |
| <input type="checkbox"/> Others (_____) | | |

5. Under medical treatment at present : No Yes

Conditions/particulars (_____)

Physical disability : No Yes

Conditions/particulars (_____)

6. Status of immunization

Indicate the date of vaccine, a physician documented history, or serologic evidence of immunity.

Varicella / Chicken pox : History of onset : Date of diagnosis (_____)
Serum Antibody Titer : _____ (date _____)
Date of vaccination : Date 1 (_____) Date 2 (_____)

Rubella : History of onset : Date of diagnosis (_____)
Serum Antibody Titer : _____ (date _____)
Date of vaccination : Date 1 (_____) Date 2 (_____)

Measles : History of onset : Date of diagnosis (_____)
Serum Antibody Titer : _____ (date _____)
Date of vaccination : Date 1 (_____) Date 2 (_____)

Mumps : History of onset : Date of diagnosis (_____)
Serum Antibody Titer : _____ (date _____)
Date of vaccination : Date 1 (_____) Date 2 (_____)

[For students / researchers with field work activities]

Tetanus : Date of vaccination : Date (_____) (within 5 Years)

[For students / researchers with medical field activities]

Hepatitis B : Serum Antibody Titer : _____ (date _____)
Date of vaccination : Date 1 (_____) Date 2 (_____) Date 3 (_____)

7. The applicant's health status is adequate to pursue studies in Japan.

YES NO

8. Additional comments. If he/she needs special supports, please describe in detail.

Physician's Signature : _____ Date : _____

Physician's Name (Print) : _____

Office/Institution : _____

Address : _____

Phone : _____ Fax : _____

E-mail address : _____