

**HEALTH CERTIFICATE**  
to GAKUSHUIN UNIVERSITY

Name : \_\_\_\_\_ Gender : \_\_\_\_\_

Date of Birth : Year Month Day Nationality : \_\_\_\_\_

**I. Examination** 検査

Height : \_\_\_\_\_ cm Weight : \_\_\_\_\_ kg Blood Pressure : \_\_\_\_\_ / \_\_\_\_\_ mmHg

Chest X-Ray : \_\_\_\_\_ (Date of Examination : Year Month Day )

\*Describe abnormalities : \_\_\_\_\_  
\_\_\_\_\_

**II. Certificate of Previous Immunization and Record of Diseases** 予防接種と既往歴の記録

Type of Immunization	Status of Immunization	Date of Vaccination	Age of Infection
Measles	<input type="checkbox"/> taken before <input type="checkbox"/> never taken <input type="checkbox"/> unsure	Dose1	<input type="checkbox"/> date unknown
		Dose2	
Rubella	<input type="checkbox"/> taken before <input type="checkbox"/> never taken <input type="checkbox"/> unsure	Dose1	<input type="checkbox"/> date unknown
		Dose2	
Mumps	<input type="checkbox"/> taken before <input type="checkbox"/> never taken <input type="checkbox"/> unsure	Dose1	<input type="checkbox"/> date unknown
		Dose2	
Varicella	<input type="checkbox"/> taken before <input type="checkbox"/> never taken <input type="checkbox"/> unsure		<input type="checkbox"/> date unknown
BCG	<input type="checkbox"/> taken before <input type="checkbox"/> never taken <input type="checkbox"/> unsure		<input type="checkbox"/> date unknown
Tuberculin skin test ( PPD , Mantoux ) within the last year	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of test: Results: _____ mm of induration	

**III. History ( Injury, illness or operation/treated, under treatment )** 既往歴(けが、病気、手術など/治療済み、治療中)

**IV. Is this applicant currently taking any medication ?** 志願者は、現在服薬をしていますか？

NO  YES → ( \_\_\_\_\_ )

**V. Has this applicant ever been allergic to anything ?** 志願者は、これまでに何らかのアレルギーがありましたか？

NO

YES → Medicine : ( \_\_\_\_\_ ) Food : ( \_\_\_\_\_ )

Other : ( \_\_\_\_\_ )

**VI. Summary** 所見

I believe this applicant ( IS / IS NOT ) physically and mentally able to study abroad.

REMARKS:

Date : Year Month Day Physician's Signature : \_\_\_\_\_

Medical Office : \_\_\_\_\_ Physician's Name : \_\_\_\_\_

Address : \_\_\_\_\_