健康診断書

（医師に記入してもらうこと）
日本語又は英語により明瞭に記載すること。

CERTIFICATE OF HEALTH

(to be completed by the examining physician)
Please fill out (PRINT/TYPE) in Japanese or English.

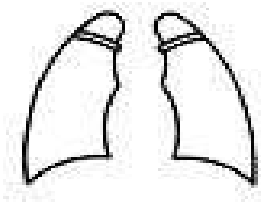
氏名 Name	Surname 姓	Given name 名	Middle name ミドルネーム

性別 Gender	☐ 男 Male ☐ 女 Female	生年月日 Date of Birth	年 月 日 yyyy mm dd	国籍 Nationality	

1. 身体検査 Physical examination

(1)身長 Height	cm		(5)血液型 Blood type	☐A ☐B ☐AB ☐O	☐RH＋☐RH－
(2)体重 Weight	kg		(6)貧血 Anemia	☐ 正常 Normal ☐ 異常 Impaired	
(3)視力 Eyesight	裸眼 Without glasses (R) (右) (L) (左)		(7)脈拍 Pulse	☐ 整 Regular ☐ 不整 Irregular	
	矯正 With glasses or contact lenses (R) (右) (L) (左)		(8)血圧 Blood pressure	/	mmHg
(4)聴力 Hearing	☐ 正常 Normal ☐ 異常 Impaired		(9)言語 Speech	☐ 正常 Normal ☐ 異常 Impaired	

2. 胸部聴診及びX線検査 （6ヶ月以内）
Physical and X-ray examinations of the chest (within six months)



胸部X線所見/**Chest X-ray findings**
Describe the condition of lungs.

撮影年月日 Date of X-ray	年 月 日 yyyy mm dd
フィルム番号 Film No.	
(1)肺 Lungs	☐ 正常 Normal ☐ 異常 Impaired
(2)心臓 Cardiomegaly	☐ 正常 Normal ☐ 異常 Impaired
異常がある場合⇒心電図 If impaired⇒Electrocardiograph	☐ 正常 Normal ☐ 異常 Impaired

3. 現在治療中の病気
Disease currently being treated

☐ 無 **None** ☐ 有 **Yes** ： 病名 Disease

4. 既往症
Past illness/disorder

該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。

Please check and fill in the date of recovery/under treatment.
If NOT contracted any of them in the past, please check "None".

✔ なし **None**

病名Name	✔	完治時期/治療中 Date of recovery /under treatment	病名Name	✔	完治時期/治療中 Date of recovery /under treatment
結核 Tuberculosis			マラリア Malaria		
その他感染症 Other communicable disease			てんかん Epilepsy		
腎疾患 Kidney disease			心疾患 Heart disease		
糖尿病 Diabetes			薬剤アレルギー Drug allergy		
甲状腺疾患 Thyroid disease			その他の疾患 Other disease		
精神疾患 Psychosis			四肢機能障害 Functional disorder in the extremities		

5. 検査
Laboratory tests

※医師の判断で省略可能
It can be omitted if the doctor judges that it is unnecessary.

(1) 尿検査 Urinalysis:	糖 glucose		蛋白 protein		潜血 occult blood		
(2) 血液検査 Blood test	赤血球数 RBC count	$\times 10^4/mm^3$	白血球数 WBC count	$/mm^3$	血色素量 Hemoglobin		g/dl
(3)肝機能検査 Liver function test	GPT (ALT)	(IU/l)					

6. 医師の診断・意見
Physician's impression of the applicant's health

継続的治療・投薬の必要性があればその旨ご記入下さい。
Please fill in if the applicant needs regular medication or treatment.

7. 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, is it your observation that his/her health status is adequate to pursue studies in Japan?

☐ はい YES ☐ いいえ NO

※必ず「はい」又は「いいえ」にチェックしてください。

日付 Date	
医師署名 Physician's Signature	
検査施設名 Office/Institution	
所在地 Address	

Questionnaire for Infection and Vaccination

Full Name : _____ Sex: Male Female

Date of Birth: _____ Nationality: _____

Affiliation : _____ Student ID: _____

E-mail: _____ Phone : _____

① Measles 麻疹	Have you ever had Measles? Yes (Year/Age: /) No Unknown		
Vaccination 疫苗 接种	First time→Yes (Year/Age: /) No Unknown	Second time→Yes (Year/Age: /) No Unknown	
② Rubella 风疹	Have you ever had Rubella? Yes (Year/Age: /) No Unknown		
Vaccination 疫苗 接种	First time→Yes (Year/Age: /) No Unknown	Second time→Yes (Year/Age: /) No Unknown	
③ Varicella (Chicken pox)水痘	Have you ever had Varicella? Yes (Year/Age: /) No Unknown		
Vaccination 疫苗 接种	First time→Yes (Year/Age: /) No Unknown	Second time→Yes (Year/Age: /) No Unknown	
④ Mumps 腮腺炎	Have you ever had Mumps? Yes (Year/Age: /) No Unknown		
Vaccination 疫苗 接种	First time→Yes (Year/Age: /) No Unknown		
⑤ Tuberculosis 结核	Have you ever had Tuberculosis? Yes (Year/Age: /) No Unknown		
Vaccination (BCG)疫苗 接种	First time→Yes (Year/Age: /) No Unknown		
⑥ COVID-19 新型冠状病毒	Have you ever had COVID-19? Yes (Year/Age: /) No Unknown		
Vaccination 疫苗 接种	First time→Yes Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☐Other ( ) ☐Unknown	Second time→Yes Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☐Other ( ) ☐Unknown	Third time→Yes Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☐Other ( ) ☐Unknown