健康診断書
Medical Information Form

Name of Applicant: _____

Home Institution: _____

Age: _____ **Height:** _____ **Weight:** _____ **Sex:** ☐Male ☐Female

TO BE SIGNED BY THE APPLICANT

I hereby waive my right to patient-doctor confidentiality in the event that NUFS, and / or any medical facility in Japan request my medical records.

Signature: _____ **Date:** _____

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TO BE COMPLETED BY A PHYSICIAN

PART I

Does the applicant now have or has he/she had any of the medical problems listed below (Please check appropriate box).

	YES	NO
a. Allergies to food or medication	☐	☐
b. Physical Handicaps	☐	☐
c. Psychiatric Disorders	☐	☐
(including Eating Disorders)	☐	☐
d. Neurological Disorders	☐	☐
e. Cardiac Problems	☐	☐
f. Arthritis	☐	☐
g. Cancer	☐	☐
h. Diabetes	☐	☐
i. Glaucoma	☐	☐
j. Hypertension	☐	☐
k. Migraine Headaches	☐	☐
l. Renal Problems	☐	☐
m. TB., Asthma, or other Respiratory Problems	☐	☐
n. Ulcers	☐	☐
o. Gynecological Problems	☐	☐
p. Learning Disability	☐	☐
q. Others	☐	☐

If you have answered yes to any of the above, please explain in detail.

Please attach additional sheet if necessary.

PART Ⅱ

1) Is the applicant currently receiving any medical treatment which would have to be continued while he / she is abroad? If yes, please describe its nature.

2) In your judgement, is there any medical reason why this applicant cannot actively participate in an extended (minimum four months) exchange program in Japan?

3) In my opinion the state of the applicant's health is:

☐Excellent ☐Good ☐Fair ☐Poor

(Please use your clinic's stamp over the print below.)

Date: _____ Signature: _____

Name (Print): _____

Position: _____

Address: _____

Zip: _____ Phone: _____