

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 NUFFS, and / or any medical facility in Japan request my medical records.

Signature: _____ Date: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
b. Physical Handicaps	<input type="checkbox"/>	<input type="checkbox"/>
c. Psychiatric Disorders (including Eating Disorders)	<input type="checkbox"/>	<input type="checkbox"/>
d. Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
e. Cardiac Problems	<input type="checkbox"/>	<input type="checkbox"/>
f. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
g. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
h. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
i. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
j. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
k. Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
l. Renal Problems	<input type="checkbox"/>	<input type="checkbox"/>
m. TB., Asthma, or other Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
n. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
o. Gynecological Problems	<input type="checkbox"/>	<input type="checkbox"/>
p. Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
q. Others	<input type="checkbox"/>	<input type="checkbox"/>

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: _____