

健康診断書 Medical Information Form

Name of Applicant: _____

Home Institution: _____

Date of Birth (DD/MM/YYYY): _____

TO BE SIGNED BY THE APPLICANT

I hereby waive my right to doctor-patient confidentiality in the event that NUFS or any medical facility in Japan requests my medical records. In addition, I understand and consent to NUFS contacting my home university regarding my medical condition if necessary.

Signature: _____ Date: _____

TO BE COMPLETED BY A PHYSICIAN

- 1) Does the applicant now have, or have they had any of the medical problems listed below? Please check appropriate box.

	YES	NO
a. Allergies to Food or Medication	☐	☐
b. Physical Disabilities	☐	☐
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	☐	☐

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

Please attach additional sheet if necessary.

- 3) Is the applicant currently receiving any medical treatment or medication which would have to be continued while they are abroad? If yes, please provide details.

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

- 5) 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: _____