Nagasaki University of Foreign Studies - JASIN Program
Health Form   健康診断書

Name: _____   ☐ Male ☐ Female   Date of Birth : _____

To be filled out by the student:

1. Do you have any health conditions the university or your accommodation should know about?
   ☐ Yes ☐ No   If so, please explain in detail :

   ※In order to provide a safe study abroad environment, it is important that you note **all** medical conditions.

2. Are you taking any medication?   ☐ Yes ☐ No
   If so, please list medications and describe in detail the condition it is treating:

3. Allergies: Please describe in detail:

   Please use the back of this form if you need more space.

To be filled out by a medical practitioner

1. (height) _____ cm   (weight) _____ kg
   (eyesight)   (hearing)   (color-perception)
   (without spectacles)   (with spectacles)   (left)   ☐ (normal)
   (left)   ／   (right)   ☐ (abnormal)
   (right)   ／

2. History of special medical conditions, allergies, or physical disabilities.
   ☐ No
   ☐ Yes   →   ☐ Medical conditions   ☐ Physical disabilities
                      ☐ Mental illnesses
                      (eg. ADHD, depression, autism, or other intellectual disabilities, etc.)
                      ☐ Allergies
                      (eg. pets, medication, stinging insects, house dust, etc.)

   Please describe.

3. Present prescription(s): (Please write in generic name; name of products may differ among countries)

4. Please check the box if there is any irregularity.
   ☐ Tonsils, nose or throat   ☐ Heart or blood vessels
   ☐ Stomach or digestive system   ☐ Genito-urinary system
   ☐ Brain or nervous system   ☐ Blood or endocrine system
   ☐ Lungs or respiratory   ☐ Bones or joints
   ☐ Other abdominal organs   ☐ Skin

   Comments

5. Tuberculosis Examination
   ☐ Normal
   ☐ To be rechecked
   ☐ Requires treatment

   (Further Remarks)

6. I diagnose that the applicant's health condition is:
   ☐Excellent   ☐Good   ☐Fair   ☐Poor
7. Do you think the applicant's condition is good enough for him/her to study in Japan?
   ☐Yes   ☐No

8. Other remarks

   I hereby certify the above diagnosis.

Physician's signature: _____   Physician's name: _____

Physician's address: _____   Date: _____

This form is valid for six months after the physician signs the document.