

CERTIFICATE OF HEALTH (to be completed by the examining physician)

Name: _____, _____ Sex: Male / Female
Family name First name Middle Name

Date of Birth: _____ Age: _____

1. Physical Examination · Laboratory tests

Height: _____ cm Weight: _____ kg

Blood Pressure: _____ mmHg ~ _____ mmHg

Urinalysis: Protein (_____) Glucose (_____) Occult Blood (_____)

Eyesight: Right (_____) Left (_____) Right (_____) Left (_____)
without glasses or contact lenses with glasses or contact lenses

Hearing: Right (normal / impaired) Left (normal / impaired)

2. Please describe the results of physical and X-ray examinations of the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).

Cardiomegaly

- normal
- impaired



Electrocardiograph

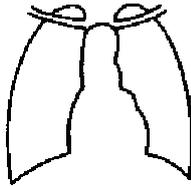
- normal
- impaired

Lungs

- normal
- impaired

Date _____

Film No. _____



Describe the condition of applicant's lungs.

3. Under medical treatment at present

- Yes (Name of illness: _____) (Name of medication: _____)
- No

4. Past history: Please indicate with A(recoverd fully), B(receiving follow-up care) or C(under treatment at present).

Name of illness ↓	Name of illness ↓
Anemia/blood disease () (_____)	Tuberculosis () (_____)
Heart disease () (_____)	Kidney disease () (_____)
Thyroid disease () (_____)	Diabetes () (_____)
Asthma () (_____)	Epilepsy () (_____)
Psychosis () (_____)	Drug allergy () (_____)
Functional disorder in extremities () (_____)	

Other medical problems or history of treatment (_____)

5. Particulars or additional comments:

I hereby certify that the above information is correct, and this student does not have any medical problems to study abroad.

Date: _____ Physician's Name (Print): _____

Address: _____

Signature: _____