SOPHIA UNIVERSITY
7-1 Kioi-cho Chiyoda-ku Tokyo
102-8554, Japan

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

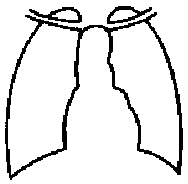
Hearing: Right (normal / impaired) Left (normal / impaired)

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 histoy: 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: _____