CERTIFICATE OF HEALTH

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| DATE OF EXAMINATION: |  |

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| --- | --- | --- | --- |
| **Full Name** |  | **Date of Birth** |  |
| **Height** |  | cm | **Weight** |  | kg |
| **Latest Tuberculin reaction** | Positive | Doubtful | Negative |
| **Eyesight** | (Left) |  | (Right) |  |
| **Physical Disability** |  | X-ray |
| 　 | Motor function disorder | Yes | No | Result |
|  | Visual impairment | Yes | No |
|  | Hearing impairment | Yes | No |
|  | Speech impairment | Yes | No |
|  | Others | Yes | No |
| **Medical History** |  | Observation |
|  | Tuberculosis | Yes  | No | Age\_\_\_\_\_ |
|  | Polio | Yes  | No | Age\_\_\_\_\_ |
|  | Bronchial asthma | Yes  | No | Age\_\_\_\_\_ |
|  | Epilepsy | Yes  | No | Age\_\_\_\_\_ |
|  | Cardiac diseases | Yes  | No | Age\_\_\_\_\_ |
|  | Neurological diseases | Yes  | No | Age\_\_\_\_\_ |
|  | Gastro-intestinal diseases | Yes  | No | Age\_\_\_\_\_ |
|  | Rheumatic fever | Yes  | No | Age\_\_\_\_\_ |
|  | Others | Yes  | No | Age\_\_\_\_\_ |

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| **If the person being checked is taking any medications on a regular basis, please write the name of the medicines.** |
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| **Blood type** | （ABO） |  | （Rh） |  |
| **HBs Ag** | Negative | Positive | **Anti-HBs** | Negative | Positive |
| **Name of Physician:** |  |
|  | （Signature） |
| **Name and address of hospital/clinic:** |
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