CERTIFICATE OF HEALTH

|  |  |
| --- | --- |
| DATE OF EXAMINATION: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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\_\_\_\_\_ | | | | |

|  |
| --- |
| **If the person being checked is taking any medications on a regular basis, please write the name of the medicines.** |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Blood type** | （ABO） | |  | | （Rh） | |  | |
| **HBs Ag** | Negative | Positive | | **Anti-HBs** | | Negative | | Positive |
| **Name of Physician:** |  | | | | | | | |
|  | （Signature） | | | | | | | |
| **Name and address of hospital/clinic:** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |