

This form should be printed for use. Visit a hospital and obtain signature or relevant information from the doctor.
Then, attach a clear scanned copy to the application. The original document should be brought at the time of enrollment and submitted to the school.

HEALTH CERTIFICATE (健康診断証明書)

Japanese Language Department
Tenrikyo Language Institute

Name of Applicant (氏名):	_____		
Date of Birth (生年月日):	____/____/____	Citizenship (国籍):	_____
Present Address (現住所):	_____		
Height (身長):	_____ cm	Weight (体重):	_____ kg
Sex (性別):	<input type="checkbox"/> Male (男)	<input type="checkbox"/> Female (女)	

1. MEDICAL HISTORY (病歴)

Please check the names of the diseases which you have ever contracted if any.

(下記の病気にかかったことがあれば病名の左の□に ✓印を記すこと)

- | | | |
|--|---|---|
| <input type="checkbox"/> Tuberculosis (結核) | <input type="checkbox"/> Poliomyelitis (小児マヒ) | <input type="checkbox"/> Jaundice (黄疸) |
| <input type="checkbox"/> Asthma (喘息) | <input type="checkbox"/> Neurosis (神経症) | <input type="checkbox"/> Anemia (貧血) |
| <input type="checkbox"/> Cardiac Disease (心疾患) | <input type="checkbox"/> Psychosis (精神病) | <input type="checkbox"/> Malnutrition (栄養障害) |
| <input type="checkbox"/> Renal Disease (腎疾患) | <input type="checkbox"/> Rheumatism (リウマチ) | <input type="checkbox"/> Major Trauma (大きな外傷) |
| <input type="checkbox"/> Epidemic or Endemic Disease (e.g., Malaria, Amebic dysentery) (伝染病、またはマラリア、アメーバ赤痢のような風土病) | | |
| <input type="checkbox"/> Others (他): _____ | | |

2. PHYSICAL FINDINGS (現症)

Vision (視力):	Right (右) _____	Left (左) _____
Color Sense (色覚):	_____	Eye Disease (眼疾): _____
Hearing (聴力):	_____	Ear Disease (耳疾): _____
Nose, Pharynx & Oral cavity (鼻、咽喉及び口腔粘膜): _____		
Skin (皮膚): _____	Lymphadenopathy (リンパ節腫張): _____	
Lung (Describe X-ray Findings if any) (胸部X線検査): _____		

Heart (心臓): _____	Abdomen (腹部): _____	
Bones, Joints, Locomotor System (骨、関節、運動器官): _____		
Other Abnormal Findings (その他身体の異常): _____		

3. GENERAL STATUS : check one (上記のもの診断結果、健康状態は…である。)

- Excellent (優) Good (良) Fair (可) Poor (不良)

Name of Physician (医師の氏名):	_____
Name of Clinic (医療機関名):	_____
Address (住所):	_____
Date (診察日):	____/____/____
Signature of Physician (医師署名):	_____