

\* 증명서는 출력해서 사용할 것. 병원 등에서 진찰을 받고 의사 서명 등을 수령한 후, 스캔한 선명한 파일을 원서에 첨부할 것.  
또한 반드시 입학 시에 증명서 원본을 학교에 제출할 것.

## 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):	_____