Take the examination from January 2019.
Examinations taken prior to this date are invalid.

Admission: April 2019

Campus: ☑ **Kunitachi** ☐ **Chiyoda**
☐ **Undergraduate** ☐ **Graduate**

Certificate of Health

Please type this form. Hand written form is NOT ACCEPTABLE.
All sections must be filled in. Where ☐ is provided, please tick off appropriate box.

1. Personal Information

Name in English	(Surname)	(Given Name)	(Middle Name)
Date of Birth	___ / ___ / ___ (month) (day) (year)	Sex	
Home Institution	Name	City	Country
Language	1st	2nd	3rd

2. Immunization Records

Measles (Rubeola), Mumps, Rubella (German Measles) and Varicella

*MR or MMR or MMRV or indivudual vaccines are acceptable

	Vaccines	Date Given		or
1	Measles (Rubeola) 2 doses OR positve titer required	Date of Does #1: ___ / ___ / ___ (month) (day) (year)	Date of Does #2: ___ / ___ / ___ (month) (day) (year)	Positive Titers ___ / ___ / ___ (month) (day) (year)
2	Mumps 2 doses OR positve titer required	Date of Does #1: ___ / ___ / ___ (month) (day) (year)	Date of Does #2: ___ / ___ / ___ (month) (day) (year)	Positive Titers ___ / ___ / ___ (month) (day) (year)
3	Rubella (German Measles) 2 doses OR positve titer required	Date of Does #1: ___ / ___ / ___ (month) (day) (year)	Date of Does #2: ___ / ___ / ___ (month) (day) (year)	Positive Titers ___ / ___ / ___ (month) (day) (year)
4	Varicella 2 doses OR positve titer OR date of disease	Date of Does #1: ___ / ___ / ___ (month) (day) (year)	Date of Does #2: ___ / ___ / ___ (month) (day) (year)	Positive Titers ___ / ___ / ___ (month) (day) (year) Date of disease ___ / ___ / ___ (month) (day) (year)

Meningococcal Disease
* ONLY if available in your country. If not, leave it blank.

Select Type

ACWY	MenA	MenC	MenA+C	MenB
___ / ___ (m) (d) (y)	___ / ___ (m) (d) (y)	___ / ___ (m) (d) (y)	___ / ___ (m) (d) (y)	___ / ___ (m) (d) (y)

3. Examination Report

Height	cm	Weight	kg	Blood Pressure	mmHg /

Chest X-ray Examination Date	☐ Normal ☐ Impaired ( ) * The X-ray examination is valid for three months before enrollment.(from January 2019) ((month) / (day) / (Year))

Any major illnesses or injury in the past of which we should be aware?	☐ Yes	☐ No
If yes, please list and include relevant medical information.		
Current medical, surgical, or psychiatric condition(s)?	☐ Yes	☐ No
If yes, please list and include relevant medical information.		
Severe food allergy?	☐ Yes	☑ No
If yes, please list		
Environmental allergy?	☐ Yes	☑ No
If yes, please list		
Is an EpiPen ® prescribed?	☐ Yes	☐ No
What recommendations do you have for his/her medical supervision? We would appreciate your sending any reports that would help us care for the patient needing continuing care or monitoring.		

4. Diagnosis

In my opinion, this applicant is able to participate fully in the school program.	☐ Yes	☐ No
Date of Examination:	(month) / (day) / (year)	

Name of Institution: _____

Name and Title of Physician (please print): _____

Signature/Seal of Physician: