For International Students/Researchers

Gifu University is providing a healthy and safe campus according to the School Health and Safety Act and the Occupational Health and Safety Act. For infection control and accommodation services, we require all participants to provide individual health information.
Please submit attached CERTIFICATE OF HEALTH completed by a physician, and issued by a medical institute.

Notice:

1. If you require special support or accommodation, please describe in detail.
2. Measles, rubella, mumps, and chicken pox are highly contagious. To prevent outbreaks on campus, all of the population must have adequate levels of immuno-defense power (antibody titers) for each infectious disease. If you have a previous history of infection or vaccination, please fill out the onset date or date of the shot. If you have no idea, measure your antibody titer with blood analysis and fill out the form attached. If the titer is insufficient, please have an additional vaccination and fill out the vaccination information.

The Health Administration Center is a support center provided to ensure a comfortable life at the university. The center provides first aid and health promotion, as well as consultations for physical and mental concerns. If you have any worries or concerns, please do not hesitate to contact us.
Personal health information is never distributed outside the Health Administration Center without your permission, except in a life-threatening emergency. Your health information will be used only for the purpose of health support and administration. You will never experience any disadvantages related to providing the health information.

Gifu University Health Administration Center,
E-mail: hokencen@gifu-u.ac.jp TEL: +81(0)58-293-2174
URL: http://www.hoken.gifu-u.ac.jp FAX: +81(0)58-293-2177

CERTIFICATE OF HEALTH (to be completed by the examining physician)

Please fill out (PRINT/TYPE) in English and mark ✓ in appropriate ☐ by a physician.

Name (Full spell): ______________________________

☐Male ☐Female

Date of Birth: ______________________________

Age: ______________________________

1. Physical Examination

(1) Height: __________ cm Weight: __________ kg

(2) Blood pressure: __________ ～ __________ mm/Hg Pulse: ☐regular ☐irregular

(3) Eyesight: (R) __________ (L) __________ ☐without ☐With glasses or contact lenses

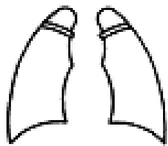
(4) Hearing: ☐normal ☐impaired

(5) Speech: ☐normal ☐impaired

(6) Lungs: ☐normal ☐impaired

(7) Heart: ☐normal ☐impaired → Electrocardiograph ( )

2. Chest X-ray examinations



Date __________ (within 3 months)

Describe the condition of applicant's lungs: ( )

3. Urinalysis: glucose ( ) protein ( ) occult blood ( )

4. Past history or present illness

☐ Tuberculosis	☐ Malaria	☐ Other infectious disease
☐ Epilepsy	☐ Psychosis	☐ Kidney disease
☐ Heart disease	☐ Lung disease	☐ Gastrointestinal disease
☐ Thyroid disease	☐ Collagen disease	☐ Diabetes mellitus
☐ Drug allergy	☐ Food allergy	

☐ Others ( )

5. Under medical treatment at present: ☐No ☐Yes

Conditions/particulars ( )

Physical disability: ☐No ☐Yes

Conditions/particulars ( )

6. Status of immunization

Indicate the date of vaccine, a physician documented history, or serologic evidence of immunity.

Varicella / Chicken pox : History of onset : Date of diagnosis ( )

Serum Antibody Titer : ______________________ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Rubella : History of onset : Date of diagnosis ( )

Serum Antibody Titer : ______________________ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Measles : History of onset : Date of diagnosis ( )

Serum Antibody Titer : ______________________ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

Mumps : History of onset : Date of diagnosis ( )

Serum Antibody Titer : ______________________ (date)

Date of vaccination : Date 1 ( ) Date 2 ( )

[For students / researchers with field work activities]

Tetanus : Date of vaccination : Date ( ) (within 5 Years)

[For students / researchers with medical field activities]

Hepatitis B : Serum Antibody Titer : ______________________ (date)

Date of vaccination : Date 1 ( ) Date 2 ( ) Date 3 ( )

7. The applicant's health status is adequate to pursue studies in Japan.

☐ YES ☐ NO

8. Additional comments. If he/she needs special supports, please describe in detail.

Physician's Signature :______________________________ Date : ________________

Physician's Name (Print) : ______________________________

Office/Institution : ______________________________

Address : ______________________________

Phone : ____________________ Fax : ____________________

E-mail address : ______________________________