

Doshisha Women's College of Liberal Arts
Japanese Studies Program 2024
Certificate of Health

Name of applicant _____ , _____ , _____ <small style="display: flex; justify-content: space-around; width: 100%;">Last First Middle</small>			Sex F	Date of birth _____ / _____ / _____ <small style="display: flex; justify-content: space-around; width: 100%;">Year Month Day</small>	Age
Nationality		Present address			
Height _____ cm		Physical examination Findings Previous illness Remarks (if the applicant is currently taking medicine or undergoing medical treatment, please explain)			
Weight _____ kg					
Vision Without glasses Corrected Right _____ (_____) Left _____ (_____)					
Color vision					
Hearing Right _____ Left _____					
Blood pressure _____ / _____ mmHg					
Chest X-ray (if available) Findings					
Urinalysis Protein Sugar Microscopic _____ _____ _____					
General state of physical condition <div style="display: flex; justify-content: space-around; width: 100%;"> Excellent Good Fair Poor </div>					
Date of report <div style="display: flex; justify-content: space-around; width: 100%;"> _____ , _____ , _____ <small style="display: flex; justify-content: space-around; width: 100%;">Month Day Year</small> </div> Signature of physician _____ Name (type or print) _____ Name and address of medical facility _____					