

To be completed by student. (Continued on reverse side)

Student Full Legal Name		
Last/Family/Surname(s)	First/Given name(s)	Middle name(s)

Date of Birth <small>example 1998/JAN/25</small>		
Yyy	mmm	dd

Student Medical Certificate

To be completed and signed by PHYSICIAN

The purpose of this form is to be aware of any student health conditions that may affect her studies before she comes to Japan.

Examination Report (current state of health)			
Height		cm	Weight
			kg
Vision	(R) _____ (L) _____	<input type="checkbox"/> without glasses or contact lenses <input type="checkbox"/> with glasses or contact lenses	
Hearing	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired		
Urinalysis	Protein ()	Glucose ()	Blood ()

Medical conditions which might affect the student's academic performance.	
Does the student have any serious past medical history or chronic illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", please indicate the name of the disease and recovery date. e.g.) Bronchial asthma, Cardiac diseases, Epilepsy, etc.	
Are there any physical or mental conditions that may limit the student's ability to study?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", please describe the condition in detail.	
Does the student have any food or drug allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", please describe.	

Do you consider the student to be in adequate mental and physical health for full and successful participation in the study abroad program?	<input type="checkbox"/> YES(adequate) <input type="checkbox"/> NO(inadequate)
If "NO", please describe the reason.	

Licensed PHYSICIAN <small>(please print clearly)</small>	Official Stamp of Institution (or clinic)
Signature(required) _____	
Name _____	
Address _____	
Telephone _____	
DATE ____ / ____ / ____	

Continued on reverse side

Tuberculosis (TB) Screening Questionnaire

Please answer the following question. (Student should mark 1-5)

1. Have you ever had close contact with persons known to have or suspected of having active TB disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? (if "Yes" , please CIRCLE the country below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had any frequent or prolonged visits to one or more of the countries listed below with a high prevalence of TB disease? (If "Yes", check the countries, below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you currently have any of the following symptoms? (If yes, please circle) —persistent fever —cough lasting greater than two weeks —unexplained weight loss —loss of appetite —unexplained fatigue —night sweats —blood tinged sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No

Afghanistan Algeria Angola Anguilla Argentina Armenia Azerbaijan Bangladesh Belarus Belize Benin Bhutan Bolivia (Plurinational State of) Bosnia and Herzegovina Botswana Brazil Brunei Darussalam Burkina Faso Burundi Cabo Verde Cambodia Cameroon Central African Republic Chad China China, Hong Kong SAR China, Macao SAR Colombia Comoros Congo Côte d'Ivoire	Democratic People's Republic of Korea Democratic Republic of the Congo Djibouti Dominican Republic Ecuador El Salvador Equatorial Guinea Eritrea Eswatini Ethiopia Fiji Gabon Gambia Georgia Ghana Greenland Guam Guatemala Guinea Guinea-Bissau Guyana Haiti Honduras India Indonesia Iraq Kazakhstan Kenya Kiribati Kyrgyzstan	Lao People's Democratic Republic Lesotho Liberia Libya Lithuania Madagascar Malawi Malaysia Maldives Mali Marshall Islands Mauritania Mexico Micronesia (Federated States of) Moldova Mongolia Morocco Mozambique Myanmar Namibia Nauru Nepal Nicaragua Niger Nigeria Niue Northern Mariana Islands Pakistan Palau Panama	Papua New Guinea Paraguay Peru Philippines Qatar Republic of Korea Republic of Moldova Romania Russian Federation Rwanda Sao Tome and Principe Senegal Sierra Leone Singapore Solomon Islands Somalia South Africa South Sudan Sri Lanka Sudan Suriname Tajikistan Thailand Timor-Leste Togo Tunisia Turkmenistan Tuvalu Uganda Ukraine United Republic of Tanzania	Uruguay Uzbekistan Vanuatu Venezuela (Bolivarian Republic of) Vietnam Yemen Zambia Zimbabwe
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Source: American College Health Association. (2024, May) Tuberculosis Screening Targeted Testing of College and University Students.

www.acha.org/guidelines. This data is obtained from the WHO Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.

<https://health.missouristate.edu/Students/tbcountries.htm>

Please show the results of this page to your physician, and ask him or her to complete the page 3.

Clinical Assessment by Physician (To physician; please review and verify the information on page 2 in questions 1-5.

Is there any YES to any of the questions in 1-5?

NO ; If "NO", no further examination is required.

You may finish with your signature at the bottom of page 1.

YES ; If "YES", please complete the following TB screening examination.

TB screening examination

6. Does the student have a history of BCG vaccination? Yes No

If "Yes", IGRA should be performed instead of TST (PPD).

If there is no history of BCG, either TST or IGRA is accepted.

Instead of performing TST or IGRA, a recent (within 2 months) result of Chest X-ray is also accepted.

7. Tuberculin Skin Test (TST) (mantoux) (PPD)ⁱ

Date Given: (/ /)(Y/M/D)

Date Read: (/ /)(Y/M/D)

Result: () mm of induration

Interpretation: positive () negative ()


8. Interferon Gamma Release Assay (IGRA)(TB blood test)

Date Obtained: (/ /)(Y/M/D)

Specify the method (QFT T-spot other_____)

Result: negative positive indeterminate borderline(T-spot only)

9. If TST or IGRA is positive; chest X-ray is REQUIRED to exclude active TB.

<p>Date : / / (yyyy/mmm/dd)</p> <p>X-rays taken more than 6 months prior to this certification are NOT valid.</p> <p>Result : <input type="checkbox"/>Normal <input type="checkbox"/>Impaired</p>	<p>Describe the condition in detail.</p> 
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ⁱ TST result should be recorded as actual millimeters of INDURATION, transverse diameter; if no induration, write "0". The test interpretation should be based on mm of induration as well as risk factors