RITSUMEIKAN

Health Certificate Form for International Students

留学生のための健康診断書

Medical Service Center, Ritsumeikan University

Name of Student (Family, Middle, Given) 氏名		Gender 性別 Male 男性, Female 女性
Birthday (M, D, Y) 誕生日	Address 住所	

Part 1: Physical and Mental Status (must be completed by Physician or Health Care Provider)

以下は英語または日本語で、医師に記載してもらうこと。

1.	Physical Examination (date:) Height ________cm, Body Weight______kg, Blood Pressure _____/_____ , Pulse _____ /min Urinalysis Protein ( ), Blood ( ), Sugar ( )
2.	Is there any significant medical, surgical or psychiatric conditions **in the past**? ☐NO ☐YES If **YES**, please describe:
3.	Is there any significant medical, surgical or psychiatric conditions **at present?** ☐NO ☐YES If **YES**, please describe: **If there is any ongoing care/treatment, provide detail on "Medical Information & Certificate"**
4.	Is there any allergies to food or medications? ☐NO ☐YES If **YES**, please describe: ※Is there any possibility of anaphylaxy? ☐NO ☐YES
5.	Recommendations regarding travel/study abroad:

Print name of Physician/Health Care Provider　　　Official Stamp (Name) of Institution (or Clinic)

Physician/Health Care Provider's Signature　　　Date

Part 2-1: Tuberculosis (TB) Screening Questionnaire　結核に関するスクリーニングです

Students should mark this page (Self-evaluation)　学生が自分で印を付けること

Name of Student (Family, Middle, Given) 氏 名

Please answer the following questions:　以下の質問に答えてください

Question	Yes	No
Have you ever had close contact with persons known or suspected to have active TB disease? 今までに、活動性の肺結核にかかっている、又は疑いのある人と接触したことがありますか？	❑ Yes はい	❑ No いいえ
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) あなたは、下記のリストにある結核高蔓延国で生まれましたか？（国名に丸を付けてください）	❑ Yes はい	❑ No いいえ

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
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
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Question	Yes	No
Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) 今まで、1つ以上の上記結核高蔓延国へ頻繁に又は、長期の訪問をしたことがありますか？ （国名に丸を付けてください）	❑ Yes はい	❑ No いいえ
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? 今までにハイリスクな施設（例：更生施設、長期の療養所、ホームレスシェルター等）に居住したこと、あるいは働いていたことはありますか？	❑ Yes はい	❑ No いいえ
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? 活動性肺結核患者のケアにボランティアまたは仕事として従事したことがありますか？	❑ Yes はい	❑ No いいえ
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? 無医療、貧困、薬物乱用またはアルコール依存症—のような、潜在性肺結核感染症または活動性肺結核のリスクが高い集団に属していたことはありますか？	❑ Yes はい	❑ No いいえ

Please show the result of this page to your physician or health care provider, and ask to complete the following Part2-2.

この結果を医師に見せて、次の Part2-2 を完成してもらってください。

Part 2-2. Clinical Assessment by Physicain or Health Care Provider　医師が記入すること

To Physician or Health Care Providers; please review and verify the information in Part2-1 "Tuberculosis (TB) Screening Questionnaire";

Name of Student (Family, Middle, Given) 氏 名

Is there any YES to any of the questions in Part 2-1?

☐ **NO**
☐ **YES**

If **NO**, no further examination is required.

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

If YES, please complete the following TB screening examination.

Does the student have a history of BCG vaccination? **Yes** _____ **No** _____

If Yes, IGRA should be performed instead of TST.

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

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

1. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)

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

Result: ________ mm of induration　　**Interpretation: positive____ negative____

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (M D Y)　　(specify the method) QFT-GIT　T-Spot　other_____

Result: negative___　positive___　indeterminate___　borderline___ (T-Spot only)

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

Chest x-ray:

Date of chest x-ray: ____/____/____ (M D Y)	Result: normal____ abnormal_____

______________________________　　______________________________

Print name of Physician / Health Care Provider　　Official Stamp (Name) of Institution (or Clinic)

______________________________　　______________________________

Signature of Physician / Health Care Provider　　Date (M, D, Y)

Appendix 1: ***Medical Information & Certificate***
病気で治療中または注意が必要な人は、医師に記載してもらってください。

To Physicians/Medical Providers who may concern,
I would appreciate it very much if you could inform me of the corresponding student's state of illness; diagnosis, course of illness/treatment (present prescription), precautions during his/her stay in Japan, and permission to travel and stay abroad for certain period, etc.

Please check your prescription if they are approved in Japan or not. Please change the prescription if considered illegal in Japan.

Thank you in advance.

Medical Service Center, Ritsumeikan University
Prof. Katsumi Nakagawa, MD, PhD
E-mail; globalhc@st.ritsumei.ac.jp

Name of Student (Fam/mid/given): Gender; male/female

Address:

Birthday (year/month/day):

Diagnosis:

#1

#2

#3

Present prescription: (Please write in generic name; name of products may differ among countries)

- **Some drugs are prohibited in Japan; ex. Methamphetamine & Amphetamine**. Check the following URL for detail: https://jp.usembassy.gov/u-s-citizen-services/local-resources-of-u-s-citizens/doctors/importing-medication/
- When **the student must carry more than one month's supply** (except prohibited drugs and controlled drugs), he/she is required to obtain a so-called **"Yakkan Shoumei", or an import certificate** in advance, and show the "Yakkan Shoumei" certificate with the prescription medicines at the Customs. Otherwise, he/she may bring up to one month's supply.

#1

#2

#3

#4

Past History, Drug & Food Allergy:

Course of Illness&Treatment, Precautions during the stay in Japan:

Permission to travel and stay abroad for the following period: From____________until_____________ .

Date:

Healthcare Provider Name, Address, AND SIGNATURE (REQUIRED):