《 HEALTH CERTIFICATE 》

NAME : _____

NATIONALITY : _____

DATE OF BIRTH : Year _____ Month _____ Day _____ **Gender :** _____

Ⅰ. EXAMINATION

HEIGHT : _____ cm WEIGHT : _____ kg BLOOD PRESSURE : _____ mmHg

CHEST X-RAY : _____ (Date of Examination : Year _____ Month _____ Day _____)

※Describe abnormalities : _____

Ⅱ. CERTIFICATE OF PREVIOUS IMMUNIZATION AND RECORD OF DISEASES

Record of Immunization

Type of Immunization	Date of Vaccination	check ✔
Measles	Dose1.	☐ unknown
	Dose2.	☐ unknown
Rubella	Dose1.	☐ unknown
	Dose2.	☐ unknown
Mumps	Dose1.	☐ unknown
	Dose2.	☐ unknown
Varicella		☐ unknown
BCG		☐ unknown
COVID-19	Dose1.	☐ unknown
	Dose2.	☐ unknown
	Dose3.	☐ unknown
Tuberculin skin test (PPD , Memtoux) within the last year	Date of test : Results : _____ mm of induretion	☐ unknown

Past History

Name of Disease	Age of Infection
Measles	
Rubella	
Mumps	
Varicella	

Ⅲ. HISTORY (Injury, illness or operation)

Ⅳ. IS THIS APPLICANT CURRENTLY TAKING ANY MEDICATION ?

☐ NO ☐ YES → ( )

Ⅴ. HAS THIS APPLICANT EVER BEEN ALLERGIC TO ANYTHING?

☐ NO
☐ Medicine → ( )
☐ Food → ( )
☐ Other → ( )

Ⅵ. SUMMARY

THIS APPLICANT (IS / IS NOT) PHYSICALLY AND MENTALLY ABLE TO STUDY ABROAD.

REMARKS:

DATE : Year _____ Month _____ Day _____ PHYSICIAN'S SIGNATURE : _____

MEDICAL OFFICE :

ADDRESS :