Doshisha Women's College of Liberal Arts
Japanese Studies Program 2027

Certificate of Health

Name of applicant	Sex	Date of birth	Age
_____, _____, _____ (Last, First, Middle)	F	_____ (Year Month Day)	

Nationality	Present address

Height _____ cm

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
_____ _____ _____

Physical examination

Findings

Previous illness

Remarks (if the applicant is currently taking medicine or undergoing medical treatment, please explain)

General state of physical condition

Excellent Good Fair Poor

Date of report

_____ (Month) , _____ (Day) , _____ (Year)

Signature of physician _____

Name (type or print) _____

Name and address
of medical facility _____