**健康証明書**

＊手書き可。 ＊１頁に収めること。 ＊英数字は半角で入力すること。 ＊当てはまる項目に☑を入れること。

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ふりがな  氏名 | |  | | | | | | | | | | | | | | | | | | 住所 | | | | | | | 〒 | | | | | | | | | | | | | | | |
| 生年月日 | | 西暦 | | |  | | | 年 | | | |  | | | 月 | | |  | | 日 | | | 年齢 | | | |  | | | | 歳 | | 性別 | | | | 男  女 | | | | | |
| **健康診断検査項目** （半年以内のもの） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 身長 | | | | | |  | | | | | | | | ｃｍ | | | 現在の健康状態 | | | | | | | | | 異常なし  異常あり  詳細： | | | | | | | | | | | | | | | | |
| 体重 | | | | | |  | | | | | | | | ｋｇ | | |
| 視力 | | | | | | 右 | | | |  | | | | | | |
| 左 | | | |  | | | | | | |
| 聴力 | | | | | | 右 | | | |  | | | | | | |
| 左 | | | |  | | | | | | |
| 尿検査 | | | | | | 糖 | | | |  | | | | | | | 心電図 | | | | | | | | | 異常なし  異常あり　詳細： | | | | | | | | | | | | | | | | |
| 蛋白 | | | |  | | | | | | |
| 血圧 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸部X線 | | | | | | 検査結果： | | | | | | | | | | | | | | | | | | | 所見： | | | | | | | | | | | | | | | | | |
| 特筆すべき  既往歴 | | | | | | なし | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| あり | | | | 詳細： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **B型肝炎免疫** （大学入学以降のもの） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HBｓ抗原 | | | ＋ ・  － | | | | | | | | | | 測定値 | | | |  | | | | | | | 検査日 | | | | 西暦 | |  | | | | 年 |  | | | 月 | |  | | 日 |
| HBｓ抗体 | | | ＋ ・  － | | | | | | | | | | 測定値 | | | |  | | | | | | | 検査日 | | | | 西暦 | |  | | | | 年 |  | | | 月 | |  | | 日 |
| HBｓワクチン接種最終日 | | | | | | | | | | | | | 西暦 | | | |  | | | | | 年 | | | | | | |  | | | 月 | | | |  | | | | | 日 | |
| 現在の健康状態に大きな問題は認められない。英国における短期実習には差し支えない健康状態であると思われる。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 西暦 |  | | | 年 | | |  | | | | 月 | | | | |  | | | 日 | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | 検査をした機関名： | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | 診断した医師の氏名： | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | |