SEINAN GAKUIN UNIVERSITY International Student Medical Report

INSTRUCTIONS: It is mandatory to submit this Medical Report for international students who wish to enroll in Seinan Gakuin University.

Name: _____ **Date of Birth:** ____/_____/_____
Last name First name (MM / DD / YYYY)

Home Institution:_____ **Gender: □Male □Female**

I. PERSONAL HISTORY (To be filled out by student)

A. IMMUNIZATION HISTORY (please check the boxes if it applies)

[Required] Two doses of Measles and Rubella are required at least one month apart OR positive immune titer verifying immunity.

Measles	Dose 1 / /	Dose 2 / /	Positive titer / /
Rubella	Dose 1 / /	Dose 2 / /	Positive titer / /

[Recommended]

Mumps	Dose 1 / /	Dose 2 / /	Positive titer / /	Disease Date / /
Chicken Pox	Dose 1 / /	Dose 2 / /	Positive titer / /	Disease Date / /

B. CURRENT/PAST HISTORY (please check the boxes if it applies)

	Infected Date/Age (MM/DD/YY)			Infected Date/Age (MM/DD/YY)			Infected Date/Age (MM/DD/YY)	
□	**Asthma**		□	**Diabetes**		□	**Epilepsy or Convulsions**	
□	**Tuberculosis**		□	**Hepatitis**		□	**High Blood Pressure**	
□	**Anemia**		□	**Kidney Disease**		□	**Bleeding Disorders**	
□	**Heart Disease**		□	**Stomach Trouble**		□	**Bone or Joint Disease**	

C. Any past/present serious injuries, surgeries, illnesses or hospitalizations_____

D. Have you ever been under treatment for a mental or emotional illness or depression? Yes_____No_____
If yes, please indicate: _____

E. Do you have any learning differences? Yes_____ No_____ If yes, please indicate: _____

F. Have you ever been treated for drug or alcohol abuse? Yes _____No_____

G. Would you want us to arrange an interview with our school doctor or counsellor on any concerns after your arrival?
Yes_____ No_____ If yes, please write down your concern: _____
_____

II. PHYSICAL EXAMINATION

This section is required to be filled out completely by physician or health care provider.

A. Height _____**cm Weight** _____**kg B. Blood Pressure** _____/_____**mmHg**
C. Vision Without Glasses: Right_____ **Left**_____ **Corrected: Right**_____ **Left** _____
D. Hearing Right_____ **Left**_____
E. Have you ever had or do you now have any of the following health problems? Check each item "Yes" or "No" and fully explain for every item marked "Yes".

	Yes	No		Yes	No		Yes	No		Yes	No
Development			**Ears**			**Eyes**			**Thyroid**		
Chest			**Heart**			**Lungs**			**Abdomen**		
Upper Extremity			**Lower Extremity**			**Neurologic**			**Psychiatric**		
Explanation of "Yes" answer(s) (Describe answer(s), give date(s) of problem, treatment given and current medical status.)											

F. Tuberculosis Control

(a) Tuberculin Skin Test or (b) TB Blood Test is required within 3 months prior to the application date. If the test is positive, (c) Chest X-ray is required.

(a) Tuberculin Skin Test (TST)

Date Given _____ /_____/_____ Date Read _____ /_____/_____

Result _____mm of induration (Positive > 10mm)

(b) TB Blood Test (Interferon Gamma Release Assay (IGRA))

Method: □ T-spot □ QFT □ other _____

Date Obtained _____ /_____/_____ Result: Negative _____ Positive _____

(c) Chest X-ray (Required if (a)TST or (b)IGRA is positive)

Date of Chest X-ray _____ /_____/_____ Findings: Normal _____ Abnormal _____

Comments:_____

_____

G. Current Medications List:

(Name/Usage/Dose) (Prescribing Physician/ Over-the-Counter Medications) (DateBegan)

_____

_____

_____

H. Activity Limitations: _____

I. Comments:

_____

_____

_____

_____

_____

Signature of Physician: _____ **Date Signed:** _____ /_____ /_____

Name of Physician: _____

Name and Address of Medical Facility: _____

Phone: _____