

SEINAN GAKUIN UNIVERSITY MEDICAL REPORT

This form must be completed by an examining physician.

Name	(Last Name)	(First Name)	Date of Birth (yyyy/mm/dd)	____ / ____ / ____
Home University			Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say

I. Required Immunizations *Fill out the date of the shot (yyyy/mm/dd) below.

Measles and Rubella are highly contagious. To prevent outbreaks on campus, SGU requires all students to receive two doses of the Measles and Rubella vaccine (at least one month apart) or provide a positive immune titer verifying immunity. A history of past infection cannot be accepted as proof of immunity.

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

II. Tuberculosis (TB) Screening Form

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

(a)	TB Skin Test (TST)	Date Given (yyyy/mm/dd): ____ / ____ / ____ Date Read (yyyy/mm/dd): ____ / ____ / ____ Result: _____ mm of induration (Positive > 10mm)
(b)	TB Blood Test (IGRA)	Method: <input type="checkbox"/> T-SPOT <input type="checkbox"/> QFT <input type="checkbox"/> Other _____ Date Obtained (yyyy/mm/dd): ____ / ____ / ____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
(c)	Chest X-ray	<u>(If the test result against (a) TST or (b) IGRA is positive)</u> Date of Chest X-ray (yyyy/mm/dd): ____ / ____ / ____ Result: <input type="checkbox"/> Not remarkable <input type="checkbox"/> Findings: _____

III. Examination Report / Present Illness

Eye-sight <input type="checkbox"/> Not remarkable <input type="checkbox"/> Findings: _____	Hearing <input type="checkbox"/> Not remarkable <input type="checkbox"/> Findings: _____
Under medical treatment at present (physical & mental)	<input type="checkbox"/> Yes (disease: _____) <input type="checkbox"/> No
If yes, please give us detailed information on his/her current medication or treatment*.	(Type of medication/treatment, frequency, etc.)
<small>*If you need to continue medication/treatment in Japan, <u>please obtain a referral letter outlining your condition and treatment history.</u></small>	
Presence of allergies (food, drug, etc.)	<input type="checkbox"/> Yes (details: _____) <input type="checkbox"/> No
Given the applicant's findings above, his/her health status is adequate for pursuing studies in Japan.	<input type="checkbox"/> Yes (Adequate) <input type="checkbox"/> No (Inadequate)
<u>Other remarks, if any:</u>	
Necessity of academic accommodation. If yes, please attach additional document(s) that describes his/her condition and recommended support.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Institution _____ Date (yyyy/mm/dd) _____

Address _____ E-mail _____

Name of Physician _____ Signature _____