健康診断書

(医師に記入してもらうこと)
日本語又は英語により明瞭に記載すること。

CERTIFICATE OF HEALTH

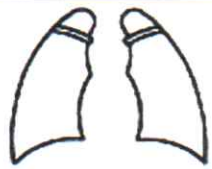
(to be completed by the examining physician)
Please fill out (PRINT/TYPE) in Japanese or English.

氏名 Name	MUHAMMAD (Surname 姓)	RAIHAN ALIF (Given name 名)		MULYAWAN (Middle name ミドルネーム)	
性別 Gender	☑ 男 Male / ☐ 女 Female	生年月日 Date of Birth	2003年 (yyyy) 04 (mm) 月 02 (dd) 日	国籍 Nationality	INDONESIA

1. 身体検査 Physical examination

(1)身長 Height	170 cm	(5)血液型 Blood type	☐A ☑B ☐AB ☐O ☑RH+ ☐RH−
(2)体重 Weight	68 kg	(6)貧血 Anemia	☑ 正常 Normal / ☐ 異常 Impaired
(3)視力 Eyesight	裸眼 Without glasses (R) 25/20 (L) 20/20	(7)脈拍 Pulse	☑ 整 Regular / ☐ 不整 Irregular
	矯正 With glasses or contact lenses (R) - (L) -	(8)血圧 Blood pressure	136 / 87 mmHg
(4)聴力 Hearing	☑ 正常 Normal / ☐ 異常 Impaired	(9)言語 Speech	☑ 正常 Normal / ☐ 異常 Impaired

2. 胸部聴診及びX線検査 (6ヶ月以内) Physical and X-ray examinations of the chest (within six months)



胸部X線所見/Chest X-ray findings Describe the condition of lungs.: NORMAL

撮影年月日 Date of X-ray: 年 (yyyy) 月 (mm) 日 (dd)

フィルム番号 Film No.: 2024/12/24/000671

(1)肺 Lungs	☑ 正常 Normal / ☐ 異常 Impaired
(2)心臓 Cardiomegaly	☑ 正常 Normal / ☐ 異常 Impaired
異常がある場合⇒心電図 If impaired⇒Electrocardiograph	☐ 正常 Normal / ☐ 異常 Impaired

3. 現在治療中の病気 Disease currently being treated

☑ 無 None ☐ 有 Yes : 病名 Disease

4. 既往症 Past illness/disorder

該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。
Please check and fill in the date of recovery/under treatment. If NOT contracted any of them in the past, please check "None".

病名 Name	✔	完治時期/治療中 Date of recovery /under treatment	病名 Name	✔	完治時期/治療中 Date of recovery /under treatment
結核 Tuberculosis			マラリア Malaria		
その他感染症 Other communicable disease			てんかん Epilepsy		
腎疾患 Kidney disease			心疾患 Heart disease		
糖尿病 Diabetes			薬剤アレルギー Drug allergy		
甲状腺疾患 Thyroid disease			その他の疾患 Other disease		
✔ ✔ なし None			精神疾患 Psychosis		
			四肢機能障害 Functional disorder in the extremities		

5. 検査 Laboratory tests

※医師の判断で省略可能 It can be omitted if the doctor judges that it is unnecessary.

(1) 尿検査 Urinalysis:	糖 glucose	Negatif	蛋白 protein	(+-) 20 mg/dL	潜血 occult blood	Negatif.	
(2) 血液検査 Blood test	赤血球数 RBC count	664 $\times 10^4/mm^3$	白血球数 WBC count	7420 $/mm^3$	血色素量 Hemoglobin	19,3	g/dl
(3)肝機能検査 Liver function test	GPT (ALT)	30 (IU/l)					

6. 医師の診断・意見 Physician's impression of the applicant's health

継続的治療・投薬の必要性があればその旨ご記入下さい。
Please fill in if the applicant needs regular medication or treatment.

- FIT -

7.

志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は充分に留学に耐えうるものと思われますか？

In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan?

☑ はい YES ☐ いいえ NO

※必ず「はい」又は「いいえ」にチェックしてください。

日付 Date	27/12/2024
医師署名 Physician's Signature	
検査機関名 Office/Institution	HASANUDDIN UNIVERSITY HOSPITAL
所在地 Address	PERINTIS KEMERDEKAAN STREET KM 10, MAKASSAR

Questionnaire for Infection and Vaccination

Full Name : MUH. RAIHAN ALIF MULIAWAN · Sex: Male ✓ ~~Female~~

Date of Birth: 02 - 04 - 2003 Nationality: INDONESIA

Affiliation : Student ID:

E-mail: Phone :

① **Measles** 麻疹	Have you ever had Measles? Yes (Year/Age: /) No ✓ Unknown	
Vaccination 疫苗 接种	First time→Yes ✓ (Year/Age: 2011 / 8 ·) No Unknown	Second time→Yes (Year/Age: /) No Unknown
② **Rubella** 风疹	Have you ever had Rubella? Yes (Year/Age: 2011 / 8 ·) No ✓ Unknown	
Vaccination 疫苗 接种	First time→Yes ✓ (Year/Age: /) No Unknown	Second time→Yes (Year/Age: /) No Unknown
③ **Varicella (Chicken pox)** 水痘	Have you ever had Varicella? Yes (Year/Age: 2014 / 11) No Unknown	
Vaccination 疫苗 接种	First time→Yes (Year/Age: /) No ✓ Unknown	Second time→Yes (Year/Age: /) No Unknown
④ **Mumps** 腮腺炎	Have you ever had Mumps? Yes (Year/Age: /) No ✓ Unknown	
Vaccination 疫苗 接种	First time→Yes ✓ (Year/Age: 2011 / 8 ·) No Unknown	
⑤ **Tuberculosis** 结核	Have you ever had Tuberculosis? Yes (Year/Age: /) No ✓ Unknown	
Vaccination (BCG)疫苗 接种	First time→Yes ✓ (Year/Age: 2003 / 1 month) No ~~✓~~ Unknown	
⑥ **COVID-19** 新型冠状病毒	Have you ever had COVID-19? Yes (Year/Age: /) No ✓ Unknown	
Vaccination 疫苗 接种	First time→Yes ✓ Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☑Other (CORONAVAC) ☐Unknown	Second time→Yes ✓ Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☑Other (CORONAVAC) ☐Unknown	Third time→Yes Year/Month/Date: / / No Unknown Yes→→→→Which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Astrazeneca ☐Other ( ) ☐Unknown