**CERTIFICATE OF HEALTH**

Attach your latest photograph here

(3x4)

**Note:**

* **This form must be completed by an examining physician in government hospital or medical laboratory (*laboratorium klinik*).**
* **All items in the form must be completed. Incomplete form will not be accepted.**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place and Date of Birth:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Male ☐ Female

Contact Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you under medical treatment?*If yes, please describe your medical conditions and treatment.*

☐ Yes ☐ No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | dd/mm/yy |  | Yes | dd/mm/yy |
| Tuberculosis |  |  | Malaria |  |  |
| Other communicable disease |  |  | Epilepsy |  |  |
| Kidney disease |  |  | Heart disease |  |  |
| Diabetes |  |  | Drug allergy |  |  |
| Psychosis |  |  | Functional disorder in exremities |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Medical history: If yes, please check and fill in the date of recovery.
2. Physical examination
	1. Height: \_\_\_\_\_\_\_ cm

Weight: \_\_\_\_\_\_\_ kg

* 1. Blood pressure: \_\_\_\_\_\_ ~ \_\_\_\_\_\_ mmHg Pulse: ☐ regular ☐ irregular
	2. Eyesight:

|  |  |  |
| --- | --- | --- |
| Without glasses | (R) | (L) |
| With glasses | (R) | (L) |

* 1. Hearing: ☐ Normal

☐ Impaired

Speech: ☐ Normal

 ☐ Impaired

* 1. Anemia: ☐ Yes

☐ No

* 1. Breath sound: ☐ Normal

☐ Impaired

* 1. Heart sound: ☐ Normal

☐ Impaired

Cardiomegaly: ☐ Yes

☐ No

Electrocardiograph: ☐ Normal

☐ Impaired

1. Please describe the result of X-ray examination of the applicant’s chest.

The examination date and Film No.are exclusively needed.

(X-rays taken more than 2 months prior to this examination are NOT valid.

Lungs: ☐ Normal

☐ Impaired

Date: / / (dd/mm/yy)

Film No.: -

Describe the condition of the applicant’s lungs.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Laboratory tests

Blood type: ☐ A ☐ B ☐ O ☐ AB RH: ☐ + ☐ -

Urinalysis: glucose ( \_\_\_\_ ), protein ( ­­\_\_\_\_ ), occult blood ( \_\_\_\_ )

ESR: \_\_\_\_\_\_\_\_ mm/Hr WBC count: \_\_\_\_\_\_\_\_\_ / mm3

Hemoglobin: \_\_\_\_\_\_\_ gm/dl GPT (ALT): \_\_\_\_\_\_\_\_\_ / U/L

1. In view of the applicant’s medical history and the above findings, do you think that his/her health status is adequate to meet the demands of studying abroad?

☐ Yes ☐ No

1. Particulars or additional comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and seal

Medical institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / -

 (dd/mm/yy)

Medical institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / -

 (dd/mm/yy)