Health Certificate Form for International Students Ritsumeikan University



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Name of Student (Family, Middle, Given)			Gender	Male, Female	
Birthday (M, D, Y) Address					
Part 1: Physical and Menta	al Status (to	be completed by He	ealth Care	Provider)	
1 Physical Examination (date	•)			
Heightcm, Body W	eightkg,	Blood Pressure _	/	_ , Pulse/min	
Urinalysis Protein (), Blood	(), Sugar ()				
2 [Past History]					
List any significant past medical	al, surgical or psychi	iatric conditions			
3 [Present illness]					
List any significant current me	edical, surgical or psy	ychiatric conditions			
If there is any ongoing care/treatr	nent, provide detail oı	n "Medical Information	& Certificate	., -	
4 [Allergy]					
List any allergies to food or me	dications: Is there a	any possibility of anaph	nylaxy?		
5 Recommendations regarding tra	avel/study abroad:				
L					
	_				
Print name of Care Care Provider		Official Stamp (Na:	me) of Instit	ution (or Clinic)	
					
Health Care Provider Signature		Date			

Part 2-1: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:							
Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No							No
Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)						No	
Afghanistan Algeria Angola Argentina Armenia Azerbaijan Bahrain Bangladesh Belarus Belize Benin Bhutan Bolivia (Plurinational State of) Bosnia and Herzegovina Botswana Brazil Brunei Darussalam Bulgaria Burkina Faso Burundi Cabo Verde Cambodia Cameroon Central African Republic Chad China Colombia Comoros Congo	Côte d'Ivoire Democratic People's Republic of Korea Democratic Republic of the Congo Djibouti Dominican Republic Ecuador El Salvador Equatorial Guinea Eritrea Estonia Ethiopia Fiji Gabon Gambia Georgia Ghana Guatemala Guinea Guinea Guinea Guinea Guinea India Indonesia Iran (Islamic Republic of) Iraq Kazakhstan	Kenya Kiribati Kuwait Kyrgyzstan Lao People's Democratic Republic Latvia Lesotho Liberia Libya Lithuania Madagascar Malawi Malaysia Maldives Mali Marshall Islands Mauritania Mauritius Mexico Micronesia Mongolia Morocco Mozambique Myanmar Namibia Nauru Nepal	Nicaragua Niger Nigeria Niue Pakistan Palau Panama Papua New Guinea Paraguay Peru Philippines Poland Portugal Qatar Republic of Korea Republic of Moldova Romania Russian Federation Rwanda Saint Vincent and the Grenadines Sao Tome and Principe Senegal Serbia Seychelles Sierra Leone Singapore Solomon Islands Somalia	Sound Sri I Sudding Suri I Sudding Suri I Sudding Suri I Sudding I Suri	name iziland kistan iland or-Leste o iidad and isia key kmenistan alu nda aine ted Repub anzania guay ekistan uatu ezuela (Be epublic of Nam nen	olic o	ıf
	ization Global Health Observatory, re updates, refer to http://apps.who.i		ntries with incidence rate	s of≥	≥ 20 cases	per	
Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) ☐ Yes ☐ No							
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?						No	
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? \Box Yes \Box No						No	
Have you ever been a member of any of the following groups that may have an increased incidence of latent <i>M. tuberculosis</i> infection or active TB disease − medically underserved, low-income, or □ Yes □ No abusing drugs or alcohol?						No	

If the answer is YES to any of the above questions, Ritsumeikan University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

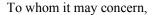
If the answer to all of the above questions is NO, no further testing or further action is required.

^{*} The significance of the travel exposure should be discussed with a health care provider and evaluated.

Part 2-2. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part 2-1. Persons answering Part 2-1 are candidates for either Mantoux tuberculin skin test (TST) or Interferon unless a previous positive test has been documented.				
History of a positive TB skin test or IGRA blood test? (If yes, document below) YesNo				
History of BCG vaccination? (If yes, consider IGRA if possible.)	Yes	No		
1. Tuberculin Skin Test (TST) (TST result should be recorded as actual millimeters (mm) of induration, transverse write "0". The TST interpretation should be based on mm of induration as well as a Date Given:// Date Read://_ M D Y Result: mm of induration **Interpretation: positive negative_ Date Given:/_/ Date Read:/_/_ M D Y Result: mm of induration **Interpretation: positive negative_ 2. Interferon Gamma Release Assay (IGRA) Date Obtained:/_/ (specify method) QFT-GIT T-Spot of M D Y Result: negative positive indeterminate borderline (T-Spot of M D Y) Date Obtained:/_/_ (specify method) QFT-GIT T-Spot of M D Y	e diameter; risk factors ther only)	if no induration,		
Result: negative positive indeterminate borderline (T-Spot 3. Chest x-ray: (Required if TST or IGRA is positive)	only)			
Date of chest x-ray:// Result: normal_	abnor	nal		
Print name of Physician / Health Care Provider Official Stamp (Name)	of Institutio	on (or Clinic)		
Signature of Physician / Health Care Provider Date (M, D, Y)				

Appendix 1: Medical Information & Certificate





I would appreciate it very much if you could inform me of the corresponding student's state of illness; diagnosis, course of illness/treatment (present prescription), precautions during his/her stay in Japan, and permission to travel and stay abroad for certain period, etc. If you may have any concern or questions, please let us know.

Thank you in advance.

Medical Service Center, Ritsumeikan University Prof. Katsumi Nakagawa, MD, PhD E-mail; globalhc@st.ritsumei.ac.jp

Name (Fam/mid/given):	Gender; male/female			
Address:				
Birthday (year/month/day):				
Diagnasia				
Diagnosis:				
#1				
#2				
#3				
Present prescription: (Please write in generic name; name of products may differ among countries)				
Past History, Drug & Food Allergy:				
Course of Illness&Treatment, Precautions during the	e stay in Japan:			
B				
Permission to travel and stay abroad for certain period:				
Data				
Date:				

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Healthcare Provider Name, Address, AND SIGNATURE (REQUIRED):