



## MEDICAL FORM (Minor) - to be completed by physician

予防接種記録・病歴 (医師に英語で記入してもらってください。)

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 参加者名 生年月日 Month/Day/Year

Name of Japanese Organization (for Japanese only): \_\_\_\_\_ State: \_\_\_\_\_  
 交流団体記入欄 州 (米国人用)

To the Examining Physician: This individual is applying for a cross-cultural exchange program. Participants live as a member of a family in a host country. Not everyone is equipped mentally and physically for this experience. The applicant must have a high degree of motivation and the ability to adjust to different social and cultural backgrounds - sometimes under difficult circumstances. Sound health is vital. Your careful and complete evaluation of the applicant's health will be helpful in determining his/her assignment. If the applicant is accepted for participation, necessary immunizations will be required.

主治医の皆様へ：上記生徒は、国際交流活動に参加いたします。つきましては、一年間の海外生活に支障のない健康状態であるかどうか、本人と面談の上、下記4枚の項目について記入し、ご署名下さいますようお願い申し上げます。

### 1. Inoculation History

#### 予防接種記録

Vaccine ワクチン	Number 回数	Date of injection 接種年月日	Vaccinated by/at 予防接種実施場所	Contracted or not? 発症歴の有無	Date contracted (M/D/Y) 発症年月日
Measles はしか	1st			Yes / No	
	2nd				
Mumps 流行性耳下腺炎	1st			Yes / No	
	2nd				
Rubella 風疹	1st			Yes / No	
	2nd				
Chickenpox 水痘				Yes / No	
Polio (OPV)小児麻痺	1st			Yes / No	
	2nd				
	3rd				
	4th				
DPT 三種混合 Diphtheria ジフテリア Pertussis 百日せき Tetanus 破傷風	1st			Yes / No	
	2nd				
	3rd				
	4th				
	5th				
Tuberculosis 結核					
Vaccine type for TB ワクチンの種類					
Hepatitis B B型肝炎	1st				
	2nd				
	3rd				
Others その他					

**2. Is this person subject to any of the following? If YES, please explain condition and/or frequency.**

下記の病気や症状がありますか？あれば症状、頻度も書き添えて下さい。

			Condition/Frequency 症状・頻度
Asthma/Respiratory Problems (喘息・呼吸器の病気)	Yes	No	_____
Diabetes/Hypoglycemia (糖尿病・低血糖)	Yes	No	_____
Heart Trouble (心臓疾患)	Yes	No	_____
Lung Trouble (肺疾患)	Yes	No	_____
Fainting Spells (失神)	Yes	No	_____
Convulsions (ひきつけ痙攣)	Yes	No	_____
Epilepsy (てんかん)	Yes	No	_____
Skin Disease (皮膚の病気)	Yes	No	_____
Kidney/Gall Bladder/Liver Disease (腎臓・胆嚢・肝臓)	Yes	No	_____
Muscular/Skeletal Problem (筋肉又は骨の障害)	Yes	No	_____
Emotional or Mental Disorder (情緒不安定)	Yes	No	_____
Stomach/Intestinal Problem (胃腸障害)	Yes	No	_____

Any Other Disorder (Please list and explain)その他の病気や症状があれば説明してください。

**3. Does he/she have any allergies or reactions to drugs or non-drug items?**

アレルギー、薬品の副作用がありますか？

- **Medicines:** 薬品でアレルギーをおこすもの

Penicillin or Related Drugs (ペニシリン系薬品) : Yes No

Aminopyrine or Sulpyrine Type Drug (ピリン系薬品) : Yes No

Others (その他) : \_\_\_\_\_

- **Non-Drug Items:** 薬品以外でアレルギーをおこすもの

Bees (蜂)    Pollen (花粉)    Dogs (犬)    Cats (猫)    Small Animals (小動物)

Foods (食べ物) \_\_\_\_\_

**4. Does he/she have difficulties with any of the following?**

下記の障害や、健康上注意を要する点がありますか？あれば、注意書きも書き添えて下さい。

			Remarks 注意書き
Eyes (視力等、目の障害)	Yes	No	_____
Uses Contact Lenses (コンタクトレンズ使用)	Yes	No	_____
Ears (聴力等、耳の障害)	Yes	No	_____
Nose (鼻の障害)	Yes	No	_____
Throat (咽喉障害)	Yes	No	_____
Digestion (消化障害)	Yes	No	_____
Sleepwalking (夢遊病)	Yes	No	_____



I have given a thorough physical examination and reviewed the medical history of the candidate. I certify that all important medical information has been included and that the above information is complete and accurate.

以上の診察の結果、この診断書に記載されていることは、すべて事実であることを証明します。

**Physician's Name/Address**

医師の氏名・住所

\_\_\_\_\_

\_\_\_\_\_

Date: Month/Day/Year \_\_\_\_\_

記入年月日 (西暦)

**Physician's official stamp and signature**

医師の署名と印