



Medical Examination Form

Fukuoka Institute of Technology

I. Personal Information

1. Name: _____
2. Gender: M/F Date of Birth: _____
3. Nationality: _____
4. Home Address: _____

II. General Health Information

1. Allergies (any drugs, food, plants, animals)

2. Explain the allergic responses:

3. Any Treatment Required

4. Current Medications: If you are under any medical treatments, please describe the conditions.

III. Clinical Examination

I certify that I have examined the following test and the result of his/her chest X-ray is as indicated ;

1. Cardiovascular System
2. Respiratory System
3. Abdomen
4. Neurological

Remarks if any:

5. Tuberculosis (BCG)

* Any evidence of active TB detected? (Pregnant Women are exempt from Chest X-Ray)

6. Measles Vaccination

Date: _____

Name of Examining Doctor (IN BLOCK LETTERS): _____

Signature of the Doctor: _____

Date: _____

Clinic's Stamp & Address: _____

Phone: _____

WARNING:

**IT IS AN OFFENCE UNDER THE IMMIGRATION ACT
TO MAKE ANY FALSE STATEMENT, REPRESENTATION OR DECLARATION**