Please tell us about any health problems you have. It is important for staff and faculty members to be aware of your health condition. Please fill in the following sections in detail. Please be aware that the school cannot give medical advice or dispense medicine. All information will be kept confidential.

|  |  |
| --- | --- |
| 1. How is your current health overall? 　Please select from the following options.
 | [ ]  Very Good [ ]  Normal [ ]  Not Good　　[ ]  Bad |
| 1. Are you currently undergoing treatment for any health issues?
 | [ ]  No[ ]  Yes  | From　　　　　　Year 　　　　Month　　　Condition（　　　　　　　　　　　 　　　　　　 　） |
| 1. Are you taking any prescribed medications? Have you been prescribed medication in the past year?
 | [ ]  No[ ]  Yes  | Prescription Date　　　 　　　Year　　　 　Month　　Medicine:　Tranquilizer　・　Antiepileptic drug・Asthma medications　Other (　　 　 　　　 　） |
| 1. Have you been hospitalised or undergone surgery in the past 5 years?
 | [ ]  No[ ]  Yes | Time in hospital　　　　　 Year　　 Month　　Reason (　　　　　　　　　　　 　　　　　　　　　　　 　　） |
| 1. Do you have a history of the following conditions, or any chronic illnesses?
 | [ ] 　No [ ] 　Yes※ If YES, please fill in the following section in detail. |
| 1. Tuberculosis
 | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　　　Month | Current Condition[ ] 　Recovered　　　　　[ ] 　Taking Medication |
| 1. Mental Health Disorder
 | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　Month | [ ]  Depression [ ]  Anxiety [ ]  Panic Attacks [ ]  Attention Deficit Disorder（ADD)[ ]  Attention Deficit Hyperactivity Disorder (ADHD) [ ]  Other ( ) |
| 1. Allergies

(including Asthma) | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　Month | [ ]  Food [ ]  Medicine [ ]  Chemical Products　[ ]  Other（　　　　　　　　　　 　　　　 ） |
| 1. Malaria, or other infectious diseases
 | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　　　Month | Disease Name: |
| 1. Diabetes
 | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　Month |  |
| 1. Other
 | [ ]  No[ ]  Yes | Symptoms Onset　　　　　Year　　　Month | Current Condition[ ] 　Recovered　　　　　[ ] 　Taking Medication |
| 1. What have you been vaccinated against?
 | [ ]  BCG [ ]  M.M.R. [ ]  Polio [ ]  Measles [ ]  Rubella [ ]  Diphtheria　[ ]  Tetanus [ ]  Meningitis [ ]  Other（　　　　　　　　　 ） |
| 1. Do you have any special dietary needs?
 | [ ]  No [ ]  Yes | From　　　　　Year　　　　MonthReason: (　　　　　　　　　　　　　　　　　　　 ） |
| 1. Please write any other information the school should know in advance.
 |

I hereby verify that the information above is true and correct.

**Signature:　　　　　　　　　　　　　　　　　　　　　　　　 　　 　　 　　　　　　　　　Date: 　　　　　 　　/Year　 　　 　　/Month 　　　 /Date**