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　　　　Month  Reason: (　　　　　　　　　　　　　　　　　　　 ） |
| 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**