**CERTIFICATE OF HEALTH**

For the as an International Student to use of applicants for admission

**To be completed by the applicant:**

Name in full\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family First Middle

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date) (month) (year) Sex □ Male □ Female

Present address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by the examining physician:**

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cm Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_kg Blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mmHg

Vision without glasses (L)\_\_\_\_\_\_\_(R)\_\_\_\_\_\_\_ With glasses (L)\_\_\_\_\_\_\_(R)\_\_\_\_\_\_\_ Hearing: □ Normal □ Impaired

History of past illness: Please indicate by □, if any.

 Tuberculosis □ Bronchial asthma □ Cardiac disease □

 Kidney disease □ Infantile paralysis □ Epilepsy □

 Nervous disease □ Mental disease □ Color blindness □

 Any other disease □

If you marked any of the above, please describe present health circumstances in detail.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculin Test □ Positive □ Negative

Please comment, if negative, on condition of applicant’s lungs, giving Date of X-ray.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe in detail if you have found any disease, acute or chronic, or any physical handicap.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 In view of the applicant’s history and the above findings, is it your observation that his/her health status is adequate to persue intended study in …………….(country)?

 Yes □ No □

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Year) (Month) (Day)

**CERTIFICATE OF HEALTH**

**(to be complete by the examining physician)**

**Please fill out (PRINT /TYPE) in English.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Male Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_

Family Name First name Middle name □ Female

 **1. Physical Examinations**

(1) Height \_\_\_\_\_\_\_\_\_\_\_ cm weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ kg

(2) Blood pressure \_\_\_\_\_\_\_\_\_\_\_\_mm/Hg~ \_\_\_\_\_\_\_\_\_\_\_\_mm/Hg Pulse rate \_\_\_\_\_\_\_\_\_\_/min □ Regular □ Irregular

(3) Eyesight (R) \_\_\_\_\_\_\_\_\_\_ (L) \_\_\_\_\_\_\_\_\_\_\_ (R) \_\_\_\_\_\_\_\_\_\_\_\_\_ (L) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ color blindness □ normal □ impaired

 Without glasses with glasses or contact lenses:

(4) Hearing: □ Normal Speech: □ Normal

 □ Impaired □ Impaired

2. Please describe the results of physical and X-ray examinations of applicant’s chest, also note the exact date of x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).

 Lung: □ normal Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiomegaly : □ normal

 □ Impaired Film No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Impaired

 Describe the condition of applicant’s lung.

3. Past history: Please indicate with + or – and fill in the date of recovery

 Tuberculosis………□ ( / / ) Malaria ……………□ ( / / ) Other communicable Disease………□ ( / / )

 Epilepsy …….……□ ( / / ) Repel Disease ………□ ( / / ) Cardiac Disease…………...….……□ ( / / )

 Diabetes …….……□ ( / / ) Drug Allergy .….……□ ( / / ) Psychosis ………………..…..……□ ( / / )

 Functional Disorder in extremities …………...………□ ( / / )

4. Laboratory tests

 Urinalysis: glucose ( ) protein ( ) occult blood ( )

 ESR: \_\_\_\_\_\_\_\_\_\_\_mm/Hr, WBC count: \_\_\_\_\_\_\_/cmm

 Hemoglobin: \_\_\_\_\_\_\_\_\_\_\_\_ gm/dl. GPT: \_\_\_\_\_\_\_\_\_\_\_

5. Please describe your impression.

In view of the applicant’s history and the above findings, is it your observation his/her health status is adequate to pursue studies in ………….?

Yes □ No□

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician’s Name in Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Office / Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SELF DECLARATION OF HEALTH

To: Khon Kaen University

 I, (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that all information in the attached medical certificate is correct and I have not suffered from any physical or mental diseases other than any mentioned in the certificate that would hinder me from studying at Khon Kaen University.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YY MM DD