**CHIANG MAI UNIVERSITY**

239 Huay Kaew Rd., Suthep, Muang,

Chiang Mai, Thailand

**CERTIFICATE OF HEALTH**

(to be complete by the examining physician)

Name: , Sex: Male / Female

Family name First name Middle name

Date of Birth: Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Physical Examination • Laboratory tests**

Height: cm. Weight: kg.

Blood Pressure: mmHg mmHg

Urinalysis: Protein ( ) Glucose ( ) Occult Blood ( )

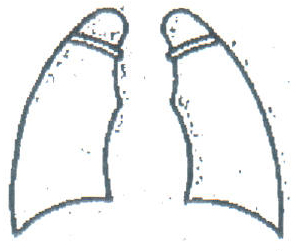
Evesight: Right ( ) Left ( ) Right ( ) Left ( )

Without glasses or contact lenses with glasses or contact lenses

Hearing: Right ( normal / impaired ) Left ( normal / impaired )

**2. Please describe the results of physical and X-ray examinations of the applicants’ chest x-rays taken more than 6 months prior to this certification are NOT valid).**

Cardiomegaly Lungs



□ normal □ normal

□ impaired □ impaired

Electrocardiograph Date of X-ray (mandatory)

□ normal Film No.\_\_\_\_\_\_\_\_\_

□ impaired

Describe the condition of applicant’s lungs

**3. Under medical treatment at present**

□ Yes (Name of illness: ) (Name of medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ No

**4. Past history: Please indicate with A (recovered fully), B (receiving follow-up care) or C (under treatment at present).**

Name of illness Name of illness

Anemia/blood disease( ) ( ) Tuberculosis ( ) ( )

Heart disease ( )( ) Kidney disease ( ) ( )

Thyroid disease ( ) ( ) Diabetes ( ) ( )

Asthma ( ) ( ) Epilepsy ( ) ( )

Psychosis ( ) ( ) Drug allergy ( ) ( )

Functional disorder in extremities ( ) ( )

Other medical problems or history treatment ( )

**5. Particulars or additional comments:**

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

I hereby certify that the above information is correct, and this student does not have any medical problems to study abroad.

Date: Physician’s Name (Print):­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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