僑 務 委 員 會

O C A C, Republic of China (Taiwan)

**2019年僑務委員會海外青年臺灣文化研習營健康證明檢查項目表**

**Health Certificate for 2019 Compatriot Youth Taiwan Culture Study Program**



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 中文姓名名： | （Name in Chinese） | | | | 檢查日期Date of Examination | | | | | | | | 相 片  Attach One  Recent 1-inch  Photo Here |
| Name in English: | | | | | 日(D) 月(M) 年(Y) | | | | | | | |
| 性別Sex：□男Male □女Female 護照號碼Passport No： | | | | | | | | | | | | |
| 出生年月日Date of Birth： / / | | | | 國籍Nationality： | | | | | | | | |
|  | | 身體檢查PHYSICAL EXAMINATION | | | | | | | | |  | |
| A.身高Height： 公分cm | | | | | | | | G.體重Weight： 公斤Kg / Lb | | | | | |
| B.脈搏Pulse： 次 / 分time / min | | | | | | | | H.視力Vision：右Right 左Left | | | | | |
| C.血壓Blood pressure： / 毫米汞柱mm Hg | | | | | | | |  | | | | | |
| D.心臟Heart： □正常Normal □異常Abnormal | | | | | | | | | | | | | |
| E.體肢運動Locomotors： □正常Normal □異常Abnormal | | | | | | | | | | | | | |
| F.疝氣Hernia： □正常Normal □異常Abnormal | | | | | | | | | | | | | |
|  | | | 檢驗室檢查LABORATORY EXAMINATIONS | | | | | | | | |  | |
| ●**未作本項目檢查者，將不予受理。【Applications not including these examinations will not be accepted.】** | | | | | | | | | | | | | |
| A.胸部Ｘ光檢查肺結核Chest Ｘ-Ray for Tuberculosis： □正常Normal □異常Abnormal | | | | | | | | | | | | | |
| B.Ｂ型肝炎表面抗原檢查Hepatitis Ｂ Surface Antigen： □陽性Positive □陰性Negative | | | | | | | | | | | | | |
|  | | 病 史MEDICAL HISTORY | | | | | | |  | | | | |
| ●您是否曾經感染下列疾病 Have you ever had the following diseases/conditions ？ | | | | | | | | | | | | | |
| A.心臟病Heart disease： □Yes □No | | | | | | E.癲癇Epilepsy： □Yes □No | | | | | | | |
| B.氣喘病Asthma： □Yes □No | | | | | | F.腎臟病Kidney disease： □Yes □No | | | | | | | |
| C.高血壓Hypertension： □Yes □No | | | | | | G.瘧疾Malaria： □Yes □No | | | | | | | |
| D.糖尿病Diabetes： □Yes □No | | | | | | | H.肝病Liver Disease： □Yes □No | | | | | | |
|  | | | | | |  | | | | | | | |
| 結論：根據以上對 先生 / 小姐之檢查結果，他 / 她 □是 □不是 合格的。 | | | | | | | | | | | | | |
| CONCLUSION：Above is the medical report of Mr. / Ms. He / She □Passed □ Failed | | | | | | | | | | | | | |
| 醫院（診所）名稱、地址、電話 | | | | | | | | | | 負責醫師簽章 | | | |
| Hospital’s or Clinic’s Name, Address and Telephone | | | | | | | | | | Chief Physician： | | | |
|  | | | | | | | | | | 〔 Name & Signature 〕 | | | |
|  | | | | | | | | | | 日期Date：日(D) 月(M) 年(Y)２０ | | | |
| 醫院負責人簽章 | | | | | | | | | |  | | | |
| Superintendent： | | | | | | | | | |
| 〔 Name & Signature 〕 | | | | | | | | | |