THAMMASAT UNIVERSITY

CERTIFICATE OF HEALTH

This Form must be completed by the physician

Student's Name First _____ Middle_____ Last _____			Birth Date (Month/Day/Year) _____
Sex _____	Age _____	Height (cm) _____	Weight (Kg) _____

Physical Examination (Please mark √)		
	Normal	Comments / Follow-up Needs
Ears		
Eyes		
Nose		
Cardiovascular		
Digestive / Urinary		
Diabetes		
Epilepsy		
Drug Allergy		
Asthma		
Other Medical Problems		

Mental Health (Please mark √)			
	Yes	No	Comments / Follow-up Needs
Depressive Disorder			
Sleep Pattern Disturbance			
Anxiety Attacks			
Bipolar Disorder			
Other Mental Health Problems			

This Student (Please mark √)

☐ Does not have any mental health problems to study abroad.

☐ Does have mental health problems but have an ability to study abroad with continuous checkup by the physician.

☐ Does have mental health problems and is not qualify to study abroad.

I hereby certify that the above information is correct.

Date:_____ Physician's Name (Print): _____

Hospital: _____ Signature:_____