Lampiran A

HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN ENGLISH LANGUAGE.
3. PLEASE WRITE IN CAPITAL LETTERS.
4. THIS FORM HAS 4 SECTIONS:
    (A) SECTION1 (PART A AND B) TO BE FILLED BY THE CANDIDATE; AND
    (B) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN 60 DAYS BEFORE REGISTRATION OR WITHIN 30 DAYS AFTER REGISTRATION.
7. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS.
8. PLEASE BRING ALONG CHEST X-RAY FILM AND REPORT FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS LABELED WITH YOUR NAME AND DATE TAKEN (IN ENGLISH).
10. CHEST X-RAY DONE WITHIN 6 MONTHS PRIOR TO REGISTRATION CAN BE ACCEPTED.
11. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO REPEAT FULL MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL PORTS SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO REJECT ANY APPLICATION:
    (A) BASED ON THE RESULTS OF THE HEALTH DOMINATION; OR
    (B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT AS GIVEN FALSE INFORMATION THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

LOGO IPT

NAME OF INSTITUTION

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

Passport size photo

PLEASE USE CAPITAL LETTERS

SECTION 1 (to be completed by candidate)
(PART A)

FULL NAME (as in passport)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH

D D M M Y Y

AGE

SEX

MALE

FEMALE

MARTIAL STATUS

SINGLE

MARRIED

ACADEMIC YEAR

/

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1

(PART B) – Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illness. * immediately family refers to father, mother, brothers/sisters.

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "yes" please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

_____ _____

_____ _____

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZATION				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

_____ _____

Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____mmHg
WEIGHT : _____ kg	PULSE RETE : _____ / min
VISION TEST : Unaided : (R)_____ (L)_____ Aided : (R)_____ (L)_____	COLOUR VISION TEST NORMAL / ABNORMAL

2. GENERAL EXAMINATION ITEM YES NO COMMENT			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION ITEM NORMAL ABNORMAL COMMENT			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY/THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN/HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 – INVESTIGATIONS

URINE TEST ITEM DATE TAKEN RESULT		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST ITEM DATE TAKEN RESULT		
ITEM	DATE TAKEN	RESULT
a. HEPETITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALATIAL PARASITE		

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4- CERTIFICATION BY THE EXAMINATION DOCTOR

Please tick (√) in the appropriate box:

I certify that I have on this date _____ examined

Mr/Ms _____Passport No. _____

and found him/her :-

☐ IN GOOD HEALTH

☐ HAVING THE FOLLOWING MEDICAL CONDITION (S) (please State)

_____

_____

_____

☐ UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date _____

Signature of Doctor _____

Name of doctor _____

Qualification _____

Hospital/Clinic _____

Registration Number _____

Official stamp _____

Remark By University Official: