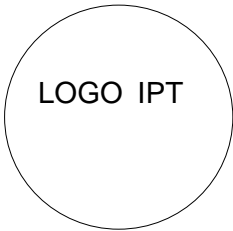


**HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS**

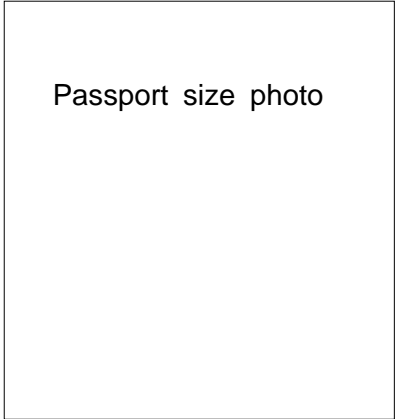
1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN ENGLISH LANGUAGE.
3. PLEASE WRITE IN CAPITAL LETTERS.
4. THIS FORM HAS 4 SECTIONS:
 - (A) SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATE; AND
 - (B) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING 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 EXAMINATION; OR
 - (B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT AS GIVEN FALSE INFORMATION THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.



NAME OF INSTITUTION



HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON



PLEASE USE CAPITAL LETTERS

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

FULL NAME (as in passport)

Grid for full name entry

INTERNATIONAL PASSPORT NO.

Grid for international passport number

NATIONALITY

Grid for nationality

CONTACT NUMBER

Grid for contact number

DATE OF BIRTH

AGE

SEX

MARTIAL STATUS

Grid for date of birth (DDMMYY)

Grid for age

Grid for sex (MALE/FEMALE)

Grid for marital status (SINGLE/MARRIED)

DDMMYY

ACADEMIC YEAR

STUDENT ID

Grid for academic year

Grid for student ID

PROGRAMME OF STUDY

PROGRAMME CODE

Grid for programme of study

Grid for programme code

NEXT OF KIN

Grid for next of kin name

NEXT OF KIN'S ADDRESS

Grid for next of kin's address

NEXT OF KIN'S CONTACT NUMBER

Grid for 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 RATE : _____ / min
VISION TEST : Unaided : (R)_____ (L)_____	COLOUR VISION TEST NORMAL / ABNORMAL
Aided : (R)_____ (L)_____	

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: