



HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INTERNATIONAL STUDENT

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 & B) TO BE FILLED BY THE CANDIDATES; AND
 - (B) SECTION 2,3 & 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN **90 DAYS** BEFORE ARRIVAL IN MALAYSIA OR WITHIN 30 DAYS AFTER REGISTRATION.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG THE **CHEST X-RAY FILM (OR DIGITAL IMAGES) AND REPORT** FOR REGISTRATION, FOR THE PURPOSE OF VERIFICATION, IF NECESSARY.
9. PLEASE ENSURE THE X-RAY FILMS OR DIGITAL IMAGES ARE **LABELLED** 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 RESERVES THE RIGHT TO **REPEAT FULL** MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. THE UNIVERSITY 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 HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

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 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 illnesses.

* Immediate 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 disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug Addiction					
14. AIDS, HIV					
15. History of Surgery					
16. Other illnesses					
17. Drug Addiction					
18. Other Illnesses					

Current medication (Long term)

VACCINATION HISTORY (where applicable)	DATE OF VACCINATION				
1. Yellow Fever *					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Polio					
6. Measles					
7. Rubella					
8. Others (specify) :					

Notes :

- *A valid Yellow fever vaccination certificate is required from all travelers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
- All students are required to take vaccines as listed in numbers 2-7 above.
- The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information

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) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL
HEARING ABILITY : : (R) _____ (L) _____	COMMENT : _____
COMMENT : _____	

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

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

SECTION 3 - INVESTIGATIONS / LABORATORY RESULTS

URINE TEST		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. OPIATES (INCLUDING CODEIN, MORPHINE, HEROIN)		
e. CANNABINOIDS		
f. AMPHEYAMINES TYPE STIMULANT (ATS)		

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

***TPHA is done if VDRL is reactive**

**** all test results / reports is valid for 3 months**

SECTION 4 – CHEST X-RAY FINDINGS

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

X-RAY REPORT :

		ABNORMAL	NORMAL	DETAILS OF ABNORMALITY
1	Thoracic Cage			
2	Heart Shape and Size (CTR> 0.55 and in failure OR significant cardiomegaly)			
3	Lung Fields			
4	Mediastinum and hilar			
5	Pleura/ Hemidiaphragms/ Costophrenic Angles			
		YES	NO	DETAILS OF ABNORMALITY
6	Focal Lesion (E.g Old/New PTB, Tumour)			
7	Any Other Abnormalities			
8	Impression			

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (✓) in the appropriate box

I certify that I have on this date _____ examined Mr / Ms _____

Passport No. _____ and found him / her :-

ITEM		YES	NO
1	HIV		
2	HEPATITIS B		
3	TUBERCULOSIS		
4	MALARIA		
5	TYPHOID		
6	SEXUALLY TRANSMITTED DISEASES		
7	CANCER		
8	PSYCHIATRIC DISORDERS		
9	EPILEPSY		
10	OTHERS (Please specify under Comments)		
I ALSO FIND THAT :		POSITIVE	NEGATIVE
11	His/her urine for amphetamine type stimulants (ATS) (screening test)		
12	His/her urine for opiates (screening test)		
13	His/her urine for cannabinoids (screening test)		

IN GOOD HEALTH

HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)

IS UNDERGOING TREATMENT FOR: (Please State)

HEREBY THE STUDENT SUITABLE / UNSUITABLE FOR STUDY (COURSE) IN MALAYSIA :

Date: _____

Signature of Doctor : _____
 Name of Doctor : _____
 Qualification and : _____
 Official stamp of Clinic : _____

Remarks By University Official:
