

**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 APPLICANT; AND
  - b) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE THE ENTIRE TEST REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPT MEDICAL EXAMINATION DONE WITHIN **90 DAYS** BEFORE ARRIVAL IN MALAYSIA.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **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 / COLLEGE 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 / 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 HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

NAME OF INSTITUTION

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

Passport size photo

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

BLOOD GROUP (RHESUS)

Grid for blood group entry

NATIONALITY

Grid for nationality entry

CONTACT NUMBER

Grid for contact number entry

DATE OF BIRTH

Grid for date of birth (DDMMYY)

AGE

Grid for age entry

SEX

MALE FEMALE

Grid for sex selection

MARITAL STATUS

SINGLE MARRIED

Grid for marital status selection

ACADEMIC YEAR

Grid for academic year entry

STUDENT ID

Grid for student ID entry

PROGRAMME OF STUDY

Grid for programme of study entry

PROGRAMME CODE

Grid for programme code entry

NEXT OF KIN

Grid for next of kin name entry

NEXT OF KIN'S ADDRESS

Grid for next of kin address entry

NEXT OF KIN'S CONTACT NUMBER

Grid for next of kin contact number entry

**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.  
 \* 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 Diseases					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart Or Vascular Diseases					
8. Asthma					
9. Thyroid Diseases					
10. Kidney Diseases					
11. Cancer					
12. History Of Surgery					
13. Tuberculosis (TB)					
14. HIV / AIDS					
15. Hepatitis B					
16. Sexually Transmitted Diseases					
17. Drug Addiction					
18. Other Illnesses					

Current medication (Long Term)

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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:

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

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
BMI : _____ (kg/m <sup>2</sup> )	
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST :  NORMAL / ABNORMAL

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

3. SYSTEMIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
4. EYES (including funduscopy)			
5. EARS			
6. NOSE			
4. ORAL CAVITY / THROAT			
5. NECK			
6. CARDIOVASCULAR			
7. RESPIRATORY			
8. ABDOMEN INCLUDING HERNIA ORIFICES			
9. NERVOUS SYSTEM			
10. MENTAL STATUS			
11. MUSCULOSKELETAL SYSTEM			

**SECTION 3 - INVESTIGATIONS**

<b>URINE TEST</b>		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. OPIATES (INCLUDING CODEIN, MORPHINE, HEROIN)		
e. CANNABINOIDS		
f. AMPHETAMINE TYPE STIMULANTS (ATS)		


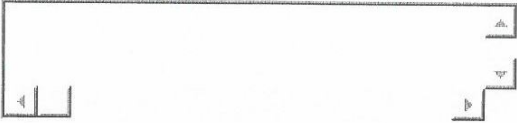


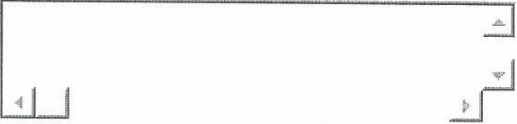


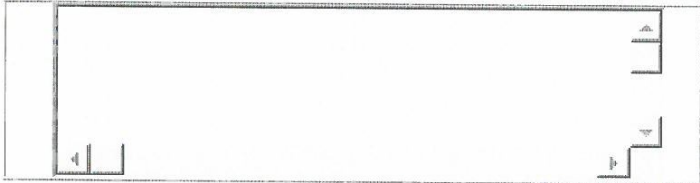
<b>BLOOD TEST</b>		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HIV ANTIBODY		
c. VDRL & TPHA*		
d. MALARIAL PARASITES		

\* TPHA is done if VDRL is reactive

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

<b>CHEST X-RAY INFORMATION</b>	
DATE TAKEN	
CHEST X-RAY NO.	
X-RAY FACILITY	

X-RAY REPORT :

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

**SECTION 4 - 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 :

IN GOOD HEALTH

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

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UNDERGOING TREATMENT FOR: (Please State)

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	YES	NO
1 HIV	<input type="checkbox"/>	<input type="checkbox"/>
2 HEPATITIS B	<input type="checkbox"/>	<input type="checkbox"/>
3 TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
4 MALARIA	<input type="checkbox"/>	<input type="checkbox"/>
5 TIFOID	<input type="checkbox"/>	<input type="checkbox"/>
6 SEXUALLY TRANSMITTED DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
7 PSYCHIATRIC DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
8 EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
OTHERS		
9 (Please specify under Comments)	<input type="checkbox"/>	<input type="checkbox"/>



I ALSO FIND THAT:

	POSITIVE	NEGATIVE
10 His/her urine for amphetamine type stimulants (ATS) (screening test)	<input type="checkbox"/>	<input type="checkbox"/>
11 His/her urine for opiates (screening test)	<input type="checkbox"/>	<input type="checkbox"/>
12 His/her urine for cannabinoids (screening test)	<input type="checkbox"/>	<input type="checkbox"/>

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

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Date : \_\_\_\_\_ Signature of Doctor : \_\_\_\_\_  
Name of Doctor : \_\_\_\_\_  
Qualification : \_\_\_\_\_  
Hospital / Clinic : \_\_\_\_\_  
Registration Number : \_\_\_\_\_  
Official stamp : \_\_\_\_\_

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Remarks By University / College Official :