LAMPIRAN A

HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSITUTIONS

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

Passport size photo

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

PLEASE USE CAPITAL LETTERS

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

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

BLOOD GROUP (RHESUS)

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL 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.
* 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)

_____

_____

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 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 WEIGHT : _____ kg BMI : _____ (kg/m^2)	BLOOD PRESSURE : _____ mmHg PULSE RATE : _____ / min
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

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

BLOOD TEST		
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**

CHEST X-RAY INFORMATION	
DATE TAKEN	
CHEST X-RAY NO.	
X-RAY FACILITY	

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/ Costopherenic Angles	☐	☐	
	YES	**NO**	**DETAILS OF ABNORMALITY**
6. Focal Lesion (E.g. Old/New PTB, Tumour)	☐	☐	
7. Any Other Abnormalities	☐	☐	

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)

_____

_____

_____

☐ UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

		YES	NO
1	HIV	☐	☐
2	HEPATITIS B	☐	☐
3	TUBERCULOSIS	☐	☐
4	MALARIA	☐	☐
5	TIFOID	☐	☐
6	SEXUALLY TRANSMITTED DISEASES	☐	☐
7	PSYCHIATRIC DISORDERS	☐	☐
8	EPILEPSY	☐	☐
9	OTHERS (Please specify under Comments)	☐	☐

I ALSO FIND THAT:

		POSITIVE	NEGATIVE
10	His/her urine for amphetamine type stimulants (ATS) (screening test)	☐	☐
11	His/her urine for opiates (screening test)	☐	☐
12	His/her urine for cannabinoids (screening test)	☐	☐

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

_____

_____

Date : _____

Signature of Doctor : _____
Name of Doctor : _____
Qualiffication : _____
Hospital / Clinic : _____
Registration Number
Official stamp : _____

_____

Remarks By University / College Official :