

**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 ALL THE TESTS 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 CHECKUP 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.

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 disease					
5	Diabetes Mellitus					
6	Hypertension					
7	Heart or vascular disease					
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 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 ²)	
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			
7. ORAL CAVITY / THROAT			
8. NECK			
9. CARDIOVASCULAR			
10. RESPIRATORY			
11. ABDOMEN INCLUDING HERNIA ORIFICES			
12. NERVOUS SYSTEM			
13. MENTAL STATUS			
14. 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	<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)

UNDERGOING TREATMENT FOR : (Please State)

	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"/>
9. OTHERS	<input type="checkbox"/>	<input type="checkbox"/>

(Please specify under Comments)

I ALSO FIND THAT:

	POSITIVE	NEGATIVE
10. His / her urine for the 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 :

Date: _____

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

Remarks By University / College Official :