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 REGISTERED MEDICAL DOCTOR

5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.

6. THE UNIVERSITY 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 **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.

PPS-03

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)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

GENDER
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

(PART B) – Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your immediate family member have/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					

Current medication (Long term) _____

_____

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
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 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

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**
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**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

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

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

SECTION 4 - CERTIFICATION BY THE REGISTERED MEDICAL 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)

_____

_____

_____

FIT TO CONTINUE

Date _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification : _____

Hospital / Clinic Registration Number : _____

Official stamp : _____

_____

Remarks By University/College Official :