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 HE TESTS REQUIRED IN THIS FORM
6. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS.
7. PLEASE BRING ALONG CHEST X-RAYS FILM AND REPORT FOR REGISTRATION.
8. PLEASE ENSURE THE X-RAY FILM IS LABELLED WITH YOUR NAME AND DATE TAKEN (IN ENGLISH)
9. CHESE X-RAY DONE WITHIN 6 MONTHS PRIOR TO REGISTRATION CAN BE ACCEPTED.
10. THE UNIVERSITY / COLLEGE RESERVE 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.
11. 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.

UNIVERSITI SAINS MALAYSIA

HEALTH EXAMINATION REPORT
FOR INTERNATIONAL STUDENT
AND ACCOMPANYING PERSON

Passport size photo with blue background

(3.5 cm x 5.0 cm)

SECTION 1 (To be completed by candidate)

(PART A)
PLEASE USE CAPITAL LETTERS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

E-MAIL ADDRESS

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/or 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					

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 examining doctor

1. BASIC MEASUREMENT	
HEIGHT :	BLOOD PRESSURE :
WEIGHT :	PULSE RATE :
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. SYSTEM 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. 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 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)

_____
_____
_____

Date: _____

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

Remarks By University/ College Official :