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 and in CAPITAL letters.

<table>
<thead>
<tr>
<th>INSTRUCTIONS TO CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This form has 5 sections:</td>
</tr>
<tr>
<td>A. Section 1 (PART A) to be filled by the student; and</td>
</tr>
<tr>
<td>B. Section 1 (PART B), 2, 3, 4 and 5 to be filled by the examining doctor.</td>
</tr>
<tr>
<td>2. Please complete all required examination / tests mentioned in this form.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSTRUCTIONS TO STUDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All applicants <strong>shall</strong> undergo health examination <strong>within seven (7) working days</strong> upon arrival in Malaysia.</td>
</tr>
<tr>
<td>2. Failure in complying with the above requirement will result in rejection of application for student pass.</td>
</tr>
<tr>
<td>3. Applicants are required to undergo health examination at approved Education Malaysia Global Services (EMGS) Panel Clinics / Health Centre of Public Universities.</td>
</tr>
<tr>
<td>4. In the event applicant fails the health examination, the student pass endorsement will not be processed and the applicant is required to leave Malaysia.</td>
</tr>
<tr>
<td>5. Applicants who fail their health examination may submit their appeal application <strong>within three (3) working days</strong> after receiving health examination result. Any application submitted after the stipulated period will not be entertained.</td>
</tr>
<tr>
<td>6. The Government of Malaysia reserves the right to reject any application:</td>
</tr>
<tr>
<td>A. Based on the results of the health examination; and/or</td>
</tr>
<tr>
<td>B. Should there be any evidence that applicant has given false information pertaining to the results of the health examination.</td>
</tr>
</tbody>
</table>
# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

## SECTION 1 (PART A)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>FULL NAME (AS IN PASSPORT)</td>
<td></td>
</tr>
<tr>
<td>INTERNATIONAL PASSPORT NUMBER</td>
<td></td>
</tr>
<tr>
<td>NATIONALITY</td>
<td></td>
</tr>
<tr>
<td>CONTACT NUMBER IN MALAYSIA</td>
<td></td>
</tr>
<tr>
<td>EMAIL ADDRESS</td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td></td>
</tr>
<tr>
<td>INSTITUTE IN MALAYSIA</td>
<td></td>
</tr>
<tr>
<td>ACADEMIC YEAR</td>
<td></td>
</tr>
<tr>
<td>COURSE OF STUDY</td>
<td></td>
</tr>
<tr>
<td>NEXT OF KIN</td>
<td></td>
</tr>
<tr>
<td>NEXT OF KIN'S ADDRESS</td>
<td></td>
</tr>
<tr>
<td>NEXT OF KIN'S CONTACT NUMBER</td>
<td></td>
</tr>
</tbody>
</table>

The medical practitioner completing this form disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering or loss caused by any reliance on this information by any other party.
**HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS**

**SECTION 1 (PART B)**

Declaration of self and family illness. Explain in full if you or your immediate* family has any of the following illnesses. * Immediate family refers to mother, brothers / sisters.

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>SELF</th>
<th>IMMEDIATE FAMILY</th>
<th>If “Yes” please state details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1. Tuberculosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Hepatitis C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Drugs use/abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Opiates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Methamphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Amphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Cannabinoids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Congenital or Inherited Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Allergy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Mental Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Stroke / Neurological Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Diabetes Mellitus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Heart or Vascular Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Thyroid Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. History of Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Sexually Transmitted Diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. History of Blood Transfusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Other Illness</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Current medication (Long Term)

<table>
<thead>
<tr>
<th>VACCINATION HISTORY (where applicable)</th>
<th>Yes</th>
<th>No</th>
<th>Date of Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yellow Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. BCG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Meningitis (Quadrivalent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Polio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Rubella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Others: (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
### HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

#### SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

**FULL NAME (AS IN PASSPORT)**

<table>
<thead>
<tr>
<th>INTERNATIONAL PASSPORT NUMBER</th>
<th>TYPE OF APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE OF MEDICAL SCREENING**

<table>
<thead>
<tr>
<th>EMGS REFERENCE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### 1. BASIC MEASUREMENT

- **HEIGHT (m):** [ ]
- **WEIGHT (kg):** [ ]
- **BMI (kg/m²):** [ ]
- **PULSE RATE (PER MINUTE):** [ ]
- **SYSTOLIC (mmHg):** [ ]
- **DIASTOLIC (mmHg):** [ ]

**VISION TEST**

<table>
<thead>
<tr>
<th>UNAIDED (L)</th>
<th>UNAIDED (R)</th>
<th>AIDED (L)</th>
<th>AIDED (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>DEFECTIVE</td>
<td>COLOR VISION TEST</td>
<td>COMMENT</td>
</tr>
</tbody>
</table>

**HEARING ABILITY**

<table>
<thead>
<tr>
<th>LEFT</th>
<th>RIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>DEFECTIVE</td>
</tr>
</tbody>
</table>

#### 2. GENERAL EXAMINATION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. DEFORMITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. PALLOR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. CYANOSIS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. JAUNDICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. OEDEMA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. SKIN DISEASES</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 3. SYSTEMIC EXAMINATION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>g. EYES (including funduscopy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. EARS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. ORAL CAVITY / THROAT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. NECK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. CARDIOVASCULAR SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. RESPIRATORY SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. ABDOMEN/HERNAL ORIFICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. NERVOUS SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. MUSCULOSKELETAL SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

4. MENTAL HEALTH ASSESSMENT
MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Untidy</th>
<th>Neat &amp; Tidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>General Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Speech Quality</td>
<td>No/Abnormal</td>
<td>Yes/Normal</td>
</tr>
<tr>
<td></td>
<td>Coherent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Mood</td>
<td>Yes/Abnormal</td>
<td>No/Normal</td>
</tr>
<tr>
<td></td>
<td>Depressed*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxious</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irritable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Affect</td>
<td>Inappropriate</td>
<td>Appropriate</td>
</tr>
<tr>
<td>E.</td>
<td>Thought</td>
<td>Yes/Abnormal</td>
<td>No/Normal</td>
</tr>
<tr>
<td></td>
<td>Delusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidality*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Perception</td>
<td>Yes/Abnormal</td>
<td>No/Normal</td>
</tr>
<tr>
<td>G.</td>
<td>Orientation</td>
<td>No/Abnormal</td>
<td>Yes/Normal</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Place</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Person</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Refer to Questionnaire. If ‘Abnormal’ for any of item C, E, F or G, to certify as UNSUITABLE.

QUESTIONNAIRE

PART A: MOOD

<table>
<thead>
<tr>
<th></th>
<th>Yes/Abnormal</th>
<th>No/Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>During the past month, have you been feeling down/depressed for most of the days?</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>During the past month, have you lost interest in doing things that you like for most of the days?</td>
<td></td>
</tr>
</tbody>
</table>

If ‘Yes’ to question A or B, to tick ‘Abnormal’ at DEPRESSED in assessment box.

PART B: SUICIDALITY

<table>
<thead>
<tr>
<th></th>
<th>Yes/Abnormal</th>
<th>No/Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>Do you feel that life is not worth living?</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Do you have any thoughts about ending your life?</td>
<td></td>
</tr>
</tbody>
</table>

If ‘Yes’ to question C or D, to tick ‘Abnormal’ at SUICIDALITY in assessment box.
HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 3 - INVESTIGATIONS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF LAB TEST

NAME OF LAB

<table>
<thead>
<tr>
<th>URINE TEST</th>
<th>POSITIVE</th>
<th>NEGATIVE</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ALBUMIN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. SUGAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. MICROSCOPIC EXAMINATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. CANNABINOID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. AMPHETAMINE TYPE STIMULANT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BLOOD TEST</th>
<th>POSITIVE / ABNORMAL</th>
<th>NEGATIVE / NORMAL</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. HEPATITIS Bs ANTIGEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. HIV ANTIBODY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. HEPATITIS C ANTIBODY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. MALARIAL PARASITES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. VDRL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. TPHA*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* TPHA is done if VDRL is reactive
**HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS**

**SECTION 4 - CHEST X-RAY INFORMATION**

<table>
<thead>
<tr>
<th>FULL NAME (AS IN PASSPORT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>INTERNATIONAL PASSPORT NUMBER</th>
<th>EMGS REFERENCE NUMBER</th>
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<table>
<thead>
<tr>
<th>DATE TAKEN</th>
<th>PLACE TAKEN</th>
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<table>
<thead>
<tr>
<th>CHEST X-RAY NUMBER</th>
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<tr>
<th>COMMENT</th>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>DETAILS OF ABNORMALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. THORACIC CAGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. HEART SHAPE AND SIZE (CTR &gt; 0.55 AND IN FAILURE OR SIGNIFICANT CARDIOMEGALY)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. LUNG FIELDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. MEDIASTNUM AND HILAR REGION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. FOCAL LESION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. ANY OTHER ABNORMALITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. IMPRESSION</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (/) the appropriate box
I certify that I have on this date ________________________ examined
Mr. / Ms. ____________________________________________
Passport Number ________________________________ and found him/her with the following disease/condition:

<table>
<thead>
<tr>
<th>TYPE OF APPLICATION</th>
<th>EMGS REFERENCE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>2.</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>3.</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>4.</td>
<td>HIV</td>
</tr>
<tr>
<td>5.</td>
<td>Cancer</td>
</tr>
<tr>
<td>6.</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>7.</td>
<td>Psychiatric Illness</td>
</tr>
<tr>
<td>8.</td>
<td>Drugs</td>
</tr>
<tr>
<td></td>
<td>a. Opiates</td>
</tr>
<tr>
<td></td>
<td>b. Amphetamine/Methamphetamine</td>
</tr>
<tr>
<td></td>
<td>c. Cannabinoids</td>
</tr>
<tr>
<td>9.</td>
<td>Malaria</td>
</tr>
<tr>
<td>10.</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>11.</td>
<td>Others (Please Specify)</td>
</tr>
</tbody>
</table>

HEREBY THE STUDENT IS CERTIFIED AS:

SUITABLE [ ] UNSUITABLE [ ]

FOR STUDIES/COURSE IN MALAYSIA.

COMMENTS:

NAME OF DOCTOR

QUALIFICATION

REGISTRATION NUMBER

DATE

HOSPITAL/CLINIC