HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. Please read the instructions carefully before filling in the form.
2. The university only accepts health examination done within 30 days of arrival in Malaysia.
3. Please fill in the form in **English** language.
4. Please write in **CAPITAL LETTERS**.
5. This form contains **4 Sections**:
   (a) Section 1 (Part A and B) - to be filled by the applicant.
   (b) Sections 2, 3 and 4 - to be completed by the examining doctor.
6. Please complete all tests required in this form.
7. Please attach **original** laboratory results and chest x-ray report.
8. The university has the right to **repeat** full medical check-up or any specific laboratory tests if there is any doubt in the medical report. All costs involved shall be borne by the applicant.
9. The university has the right to **reject** any application:
   (a) Based on the results of the health examination.
   (b) If the applicant has provided false information in the health examination report or any supporting documents.

UNIVERSITI KEBANGSAAN MALAYSIA
The National University of Malaysia

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

Passport size photo

PLEASE USE CAPITAL LETTERS

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

NAME			
PASSPORT NO.			
NATIONALITY			
STUDENT NO.			
DATE OF BIRTH (DD / MM / YYYY)		**AGE**	
GENDER	**MALE / FEMALE**	**MARITAL STATUS**	**SINGLE / MARRIED**
PHONE NUMBER			
FACULTY			
ACADEMIC YEAR	**20 ___ / 20 ____**		
NEXT OF KIN			
NEXT OF KIN'S PHONE 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 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					
17. Smoker					
18. Hepatitis B / Hepatitis C					
19. Sexually transmitted diseases					

Current medication (Long term)

_____

_____

_____

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
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			
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. AMPHETAMINE TYPE STIMULANTS		

* Please attach all **original** laboratory results

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

* Please attach all **original** laboratory results

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 :-

☐ THE ABOVE NAMED IS IN GOOD HEALTH

☐ THE ABOVED NAMED HAS THE FOLLOWING MEDICAL PROBLEM
(Please State)

_____

_____

☐ THE ABOVE NAMED IS UNDERGOING TREATMENT FOR:
(Please State)

_____

_____

_____

Date :_____

Signature of Doctor :

Name of Doctor :

Qualification :

Hospital/Clinic :
Dr.'s Registration Number

Official stamp :

Remarks By University Official :