

## GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT

1. PLEASE READ THIS 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 2 SECTIONS
  - SECTION 1 (PART A & B) TO BE FILLED BY THE CANDIDATES
  - SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TEST REQUIRED IN THIS FORM
6. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS AND THE RESULTS MUST BE REPORTED IN ENGLISH. IT MUST BE DONE WITHIN 2 MONTHS PRIOR TO REGISTRATION
7. PLEASE BRING ALONG THE CHEST X-RAY FILM AND REPORT
  - a. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (**IN ENGLISH**)
  - b. CHEST X-RAY MUST BE DONE **WITHIN 6 MONTHS** PRIOR TO REGISTRATION
8. UNIVERSITY HEALTH CENTRE CONCERNED HAS THE RIGHT TO **REPEAT** THE MEDICAL CHECK-UP SHOULD THERE BE ANY DOUBT OF THE MEDICAL REPORT. ALL COST INVOLVED WILL BE PAID BY THE CANDIDATES
9. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION:
  - a. BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
  - b. SHOULD THERE BE ANT EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

## 1. Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
<ul style="list-style-type: none"> <li>Contagious</li> <li>Recover is expected to be difficult and delayed</li> </ul>	<ul style="list-style-type: none"> <li>HIV/AIDS</li> <li>Hepatitis B</li> <li>Hepatitis C</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is prohibited</li> </ul>
<ul style="list-style-type: none"> <li>Contagious</li> <li>Expected to recover with treatment</li> </ul>	<ul style="list-style-type: none"> <li>Tuberculosis</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is must be deferred until treatment in home country is completed</li> <li>Deferment should not be for more than two semester</li> <li>Registration requires confirmation from the physician in charge that treatment has been completed</li> </ul>
<ul style="list-style-type: none"> <li>Contagious</li> <li>Expected to recover with treatment</li> </ul>	<ul style="list-style-type: none"> <li>Malaria</li> <li>Typhoid</li> <li>Syphilis</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is allowed only after treatment is completed in home country</li> </ul>
<ul style="list-style-type: none"> <li>Contagious disease that are declared as epidemic by the Malaysian Ministry of Health</li> </ul>	<ul style="list-style-type: none"> <li>Japanese Encephalitis</li> <li>SARS</li> <li>Avian Flu</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is prohibited</li> </ul>

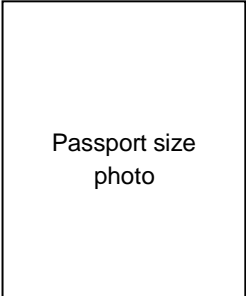
## 2. Non – Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
<ul style="list-style-type: none"> <li>An attack that may harm the student or other</li> </ul>	<ul style="list-style-type: none"> <li>Epilepsy</li> <li>Schizophrenia</li> </ul>	<p>A report is required from the treating specialist. May be accepted for registration / admission if any of the following is met:</p> <ul style="list-style-type: none"> <li>Symptom-free for &gt;12 months</li> <li>Treatment is completed</li> </ul>
<ul style="list-style-type: none"> <li>Disease or disorder is expected to continue for an unspecified time</li> <li>Apparent and serious symptoms</li> <li>Long treatment schedule</li> </ul>	<ul style="list-style-type: none"> <li>End stage renal failure requiring dialysis</li> <li>Cancer</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is prohibited</li> </ul>
<ul style="list-style-type: none"> <li>Addiction that is direct violation of the Malaysia laws</li> </ul>	<ul style="list-style-type: none"> <li>Drugs</li> <li>Morphine</li> <li>Canabis</li> <li>Ampethamine</li> <li>Metampethamine</li> </ul>	<ul style="list-style-type: none"> <li>Registration / admission is prohibited</li> </ul>
<ul style="list-style-type: none"> <li>Requires continuous medication</li> <li>No serious symptoms</li> <li>Treatment not affecting study</li> </ul>	<ul style="list-style-type: none"> <li>Hypertension</li> <li>Diabetes Mellitus</li> </ul>	<ul style="list-style-type: none"> <li>May register if treatment does not affect study</li> </ul>



HEALTH EXAMINATION REPORT
CENTRE FOR POSTGRADUATE STUDIES

PLEASE USE CAPITAL LETTERS
SECTION 1 (To be completed by candidate)
(PART A)



FULL NAME (AS IN PASSPORT)

Grid for full name entry

INTERNATIONAL PASSPORT NO.

Grid for international passport number

NATIONALITY

Grid for nationality

CONTACT NUMBER

Grid for contact number

DATE OF BIRTH

Grid for date of birth with labels D D M M Y Y

AGE

Grid for age

SEX

Grid for sex with labels MALE FEMALE

MARITAL STATUS

Grid for marital status with labels SINGLE MARRIED

ACADEMIC YEAR

Grid for academic year with slash separator

STUDENT ID

Grid for student ID

PROGRAMME OF STUDY

Grid for programme of study

PROGRAMME CODE

Grid for programme code

NEXT OF KIN

Grid for next of kin name

NEXT OF KIN'S ADDRESS

Grid for next of kin's address

NEXT OF KIN'S CONTACT NUMBER

Grid for next of kin's contact 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. AIDS,HIV					
2. Hepatitis B/C					
3. Congenital or inherited disorder					
4. Allergy					
5. Mental illness					
6. Fits,stroke,other neurological disease					
7. Diabetes Mellitus					
8. Hypertension					
9. Heart or vascular disease					
10. Asthma					
11. Thyroid disease					
12. Kidney disease					
13. Cancer					
14. Tuberculosis					
15. Drug addiction					
16. History of surgery					
17. Other illnesses					

Current medication (Long term)

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IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZAD				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true understand that my application will be rejected if there is any false information given.

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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) _____	COLOR VISION TEST :  NORMAL / ABNORMAL

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**

<b>URINE TEST</b>		
<b>ITEM</b>	<b>DATE TAKEN</b>	<b>RESULT</b>
URINE FEME		
URINE DRUG * (*completed by UMK Medical Officer) a) Morphine b) Canabis c) Ampethamine d) Metampethamine		

<b>CHEST X-RAY INFORMATION</b>	
CHEST X-RAY INFORMATION 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)

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UNDERGOING TREATMENT FOR: (Please State)

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Date \_\_\_\_\_

Signature of Doctor

: \_\_\_\_\_

Name of Doctor

: \_\_\_\_\_

Qualification

: \_\_\_\_\_

Hospital / Clinic

: \_\_\_\_\_

Registration Number

: \_\_\_\_\_

Official stamp

: \_\_\_\_\_

Remarks By UMK Medical Officer :

**Carta Alir Pemeriksaan Kesehatan Pelajar Antarabangsa di IPT Malaysia**  
**Lampiran B**

