



MEDICAL EXAMINATION FORM (INTERNATIONAL)

(Please submit this completed form at the University Health Centre counter for review on the day of registration)

HEALTH SCREENING GUIDELINE FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

- 1 ALL APPLICANTS SHALL UNDERGO HEALTH SCREENING WITHIN SEVEN (7) WORKING DAYS UPON ARRIVAL IN MALAYSIA.
- 2 FAILURE IN COMPLYING WITH THE ABOVE MATTER WILL RESULT IN REJECTION OF APPLICATION FOR STUDENT PASS.
- 3 APPLICANTS ARE REQUIRED TO UNDERGO HEALTH SCREENING AT CERTIFIED EDUCATION MALAYSIA GLOBAL SERVICES (EMGS) PANEL CLINICS / HEALTH CENTRE OF PUBLIC UNIVERSITIES
- 4 PLEASE FILL IN THE FORM IN **ENGLISH**.
- 5 IF THE APPLICANT FAILED THE HEALTH SCREENING, STUDENT PASS ENDORSEMENT WILL NOT BE PROCESSED AND THE APPLICANT IS REQUIRED TO LEAVE MALAYSIA.
- 6 APPLICANTS WHO FAILED THEIR HEALTH SCREENING **MAY** SUBMIT THEIR APPEAL APPLICATION WITHIN THREE (3) WORKING DAYS AFTER RECEIVING HEALTH SCREENING RESULT. ANY APPLICATION SUBMITTED AFTER STIPULATED PERIOD WILL NOT BE PROCESSED.
- 7 APPLICANTS WILL HAVE TO UNDERGO CONFIRMATORY TEST WITH THE INITIAL SAMPLE FOR APPEAL APPLICATION AT PREVIOUS CLINIC
- 8 THE GOVERNMENT OF MALAYSIA RESERVES THE RIGHT TO REJECT ANY APPLICATION:
 - a). BASE ON THE RESULT OF THE HEALTH EXAMINATION;
 - b). SHOULD THERE BE ANY EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION PERTAINING TO THE RESULTS OF THE HEALTH EXAMINATION.

SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT):

INTERNATIONAL PASPORT NUMBER:

NATIONALITY:

DATE OF BIRTH:

AGE:

SEX:

MARITAL STATUS:

EMAIL ADDRESS:

CONTACT NUMBER IN MALAYSIA:

INSTITUTION IN MALAYSIA:

ACADEMIC YEAR:

COURSE OF STUDY:

NEXT OF KIN:

NEXT OF KIN'S ADDRESS:

NEXT OF KIN'S CONTACT NUMBER:

The medical practitioner completing this form disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering and loss caused by any reliance on this information by any other party.

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.

ITEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state
	Yes	No	Yes	No	
1 Tuberculosis					
2 Leposy					
3 Hepatitis B					
4 Hepatitis C					
5 HIV					
6 Drugs use/abuse:					
a. Oplates					
b. Methamphetamine					
c. Amphetamine					
d. Cannabinoids					
7 Congenital or Inherited Disorder					
8 Allergy					
9 Mental Illness					
10 Epilepsy					
11 Stroke / Neurological Disease					
12 Diabetes Mellitus					
13 Hypertension					
14 Heart or Vascular Disease					
15 Asthma					
16 Thyroid Disease					
17 Kidney Disease					
18 Cancer					
19 History of Surgery					
20 Sexually Transmitted Disease					
21 History of Blood Transfusion					
22 Other Illnesses					
.....					
.....					

Current medication (Long Term)

VACCINATION HISTORY (where applicable)		Yes	No	Date of Vaccination
1	Yellow Fever			
2	BCG			
3	Meningitis (Quadrivalent)			
4	Hepatitis B			
5	Polio			
6	Measles			
7	Rubella			
8	Others: (specify)			
9	Other Illnesses			

Notes:

- 1.. A valid Yellow Fever vaccination certificate is required from all travelers 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 number 2-7 above.
- 3.. The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

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.

.....
 (Signature of Applying Candidate)

Date:

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

FULL NAME (AS IN PASSPORT):

INTERNATIONAL PASPORT NUMBER:

TYPE OF APPLICATION:

DATE OF MEDICAL SCREENING:

1. BASIC MEASUREMENT

HEIGHT(m)

WEIGHT(kg)

BMI (kg/m²)

PULSE RATE
(PER MINUTE)

BLOOD PRESSURE

SYSTOLIC DIASTOLIC
(mmHg) (mmHg)

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VISION TEST

UNAIDED (L)
UNAIDED (R)
AIDED (L)
AIDED (R)

NORMAL DEFECTIVE

**COLOUR VISION TEST
COMMENT**

HEARING ABILITY

LEFT
RIGHT

NORMAL DEFECTIVE

COMMENT

2. GENERAL EXAMINATION

ITEM
a. DEFORMITIES
b. PALLOR
c. CYANOSIS
d. JAUNDICE
e. CEDEMA
f. SKIN DISEASE

NORMAL DEFECTIVE

COMMENT

3. SYSTEMIC EXAMINATION

ITEM
a. EYES (including
b. EARS
c. NOSE
d. ORAL CAVITY/THROAT
e. NECK
f. CARDIOVASCULAR
m. RESPIRTORY SYSTEM
n. ABDOMEN/HERNIAL
o. NERVOUS SYSTEM
p. MUSCULOSKELETAL

NORMAL DEFECTIVE

COMMENT

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A	General Appearance		Neat & Tidy	<input type="text"/>		Untidy	<input type="text"/>
B	Speech Quality	Coherent	Yes	<input type="text"/>		No	<input type="text"/>
		Relevant	Yes	<input type="text"/>		No	<input type="text"/>
C	Mood	Depressed	Yes	<input type="text"/>		No	<input type="text"/>
		Anxious	Yes	<input type="text"/>		No	<input type="text"/>
		Irritable	Yes	<input type="text"/>		No	<input type="text"/>
D	Affect		Appropriate	<input type="text"/>		Inappropriate	<input type="text"/>
E	Thought	Delusion	Yes	<input type="text"/>		No	<input type="text"/>
		Suicidality	Yes	<input type="text"/>		No	<input type="text"/>
F	Perception		Hallucination	Yes	<input type="text"/>	No	<input type="text"/>
G	Orientation	Time	Yes	<input type="text"/>		No	<input type="text"/>
		Place	Yes	<input type="text"/>		No	<input type="text"/>
		Person	Yes	<input type="text"/>		No	<input type="text"/>

Note: Refer to Questionnaire

If 'Yes' for any of item C, E, F or G to certify as UNSUITABLE.

QUESTIONNAIRE**PART A: MOOD**

- 1 During the past month, have you been feeling down/ depressed for most of the days? Yes No
- 2 During the past month, have you lost interest in doing things that you like for most of the days? Yes No

If 'Yes' to question 1 or 2, to tick 'Yes' at DEPRESSED in assessment box.

PART B: SUICIDALITY

- 3 Do you feel that life is not worth living? Yes No
- 4 Do you have any thoughts about ending your life? Yes No

If 'Yes' to question 3 or 4, to tick 'Yes' at SUICIDALITY in assessment box.

SECTION 3 - INVESTIGATIONS

URINE TEST

ITEM	POSITIF	NEGATIF	COMMENT
a. ALBUMIN b. SUGAR c. MICROSCOPIC EXAMINATION d. OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN) e. CANNABINOIDS f. AMPHETAMINE TYPE STIMULANT			

BLOOD TEST

ITEM	POSITIF/ ABNORMAL	NEGATIF/ NORMAL	COMMENT
a. HEPATITIS B's ANTIGEN b. HIV ANTIBODY c. HEPATITIS C ANTOBODY d. MALARIA PARASITES e. VDRL & TPHA*			

*TPHA is done if VRDL is reactive

X - RAY REPORT

CHEST X RAY INFORMATION

DATE TAKEN _____

CHEST X-RAY NUMBER _____

PLACE TAKEN _____

ITEM	NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
a. THORACIC CAGE			
b. HEART SHAPE AND SIZE (CTR>0.55 AND IN FAILURE OR SIGNIFICANT CARDIOMEGALY)			
c. LUNG FIELDS			
d. MEDIASTINUM AND HILAR REGION			
e. PLEURA/ HEMIDIAPHRAGMS/ COSTOPHRENIC ANGLES			
f. FOCAL LESION			
g. ANY OTHER ABNORMALITIES			
h. IMPRESSION			

SECTION 4 - 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:

ITEMS	ABNORMAL
1. Tuberculosis 2. Leposy 3. Hepatitis B 4. Hepatitis C 5. HIV 6. Cancer 7. Epilepsy 8. Psychiatric Illness 9. Drugs : a. Oplates b. Methamphetamine c. Amphetamine d. Cannabinoids 10. Others (Please specify): _____ _____	

HEREBY THE STUDENT IS CERTIFIED AS:

SUITABLE

UNSUITABLE

FOR STUDIES / COURSE IN MALAYSIA

COMMENTS:

Date: _____

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

HEALTH DECLARATION FORM FOR APPLICANTS

I hereby declare that I am free from the following diseases/conditions:

ITEMS	SELF		IF NO, PLEASE STATE
	Yes	No	
1. Tuberculosis			
2. Leposy			
3. Hepatitis B			
4. Hepatitis C			
5. HIV			
6. Drugs :			
a. Oplates			
b. Methamphetamine			
c. Amphetamine			
d. Cannabinoids			
7. Sexually Transmitted Disease			
8. Congenital or Inherited Disorder			
9. Cancer			
10. Epilepsy			
11. Psychiatric Illness			
12. Other Illness			

IF YOU HAVE SOUGHT CONSULTATION FOR ANY OF THE LISTED DISEASE/CONDITION, YOU ARE REQUIRED TO SUBMIT YOUR MEDICAL HISTORY/ REPORT FROM YOUR TREATING PHYSICIAN TO EDUCATION MALAYSIA GLOBAL SERVICES (EMGS) PANEL CLINIC/ UNIVERSITY HEALTH CENTRE

I declare that I will submit myself for compulsory Post-Arrival Health Examination as per Malaysian regulations. In the event that I should be diagnosed with any condition that deems me UNSTUITABLE for studies, I will bear the cost of leaving Malaysia and will adhere to the immigration requirements on the visit pass and exit before the pass expiration, or any deadline given to me whichever is earlier.

I declare that in the event I should be diagnosed with any conditions that does bnot require my removal from Malaysia but requires medical treatment and I choose to remain in Malaysia to continue my studies, I will bear any and all costs relating directly or indirectly towards the medical management of my medical condition.

I confirm that EMGS Panel Clinic/University Health Centre shall not be responsible in any manner or whatsoever, arising out of EMGS Panel Clinic/University Health Centre certification of my medical status as suitable to study or reside in Malaysia despite the medical condition described above. I Futher undertake to hold EMGS Panel Clinic/University Health Centre harmless from any loss or liability arising from this decision and agree to indemnify and keep EMGS Panel Clinic/University Health Centre from any loss or liability arising from this decision.

.....
Date

.....
Name of applicant as Indicated in the passport

.....
Applicant's signature

.....
Applicant's passport number