Universiti Tun Hussein Onn Malaysia

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 extend permitted by law for any personal injury, suffuring 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 Ilnesses					
	……..					
	…….					

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 Ilnesses			

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/m')	PULSE RATE (PER MINUTE)	BLOOD PRESSURE	
				SYSTOLIC (mmHg)	DIASTOLIC (mmHg)

VISION TEST	NORMAL	DEFECTIVE	COLOUR VISION TEST COMMENT
UNAIDED (L)			
UNAIDED (R)			
AIDED (L)			
AIDED (R)			

HEARING ABILITY	NORMAL	DEFECTIVE	COMMENT
LEFT			
RIGHT			

2. GENERAL EXAMINATION

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

3. SYSTEMIC EXAMINATION

ITEM	NORMAL	DEFECTIVE	COMMENT
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			

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A	**General Appearance**		Neat & Tidy		Untidy	
B	**Speech Quality**	Coherent	Yes		No	
		Relevent	Yes		No	
C	**Mood**	Depressed	Yes		No	
		Anxious	Yes		No	
		Irritable	Yes		No	
D	**Affect**		Appropriate		Inappropriate	
E	**Thought**					
	Delusion		Yes		No	
	Suicidality		Yes		No	
F	**Perception**					
	Hallucination		Yes		No	
G	**Orientation**					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

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				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
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				

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