



MEDICAL EXAMINATION FORM (INTERNATIONAL)

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

LAMPIRAN A

HEALTH EXAMINATION GUIDELINE FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

- 1 ALL APPLICANTS **SHALL** UNDERGO HEALTH EXAMINATION 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 EXAMINATION 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 EXAMINATION, STUDENT PASS ENDORSEMENT WILL NOT BE PROCESSED AND THE APPLICANT IS REQUIRED TO LEAVE MALAYSIA.
- 6 APPLICANTS WHO FAILED THEIR HEALTH EXAMINATION **MAY** SUBMIT THEIR APPEAL APPLICATION WITHIN THREE (3) WORKING DAYS AFTER RECEIVING HEALTH EXAMINATION RESULT. ANY APPLICATION SUBMITTED AFTER THE STIPULATED PERIOD WILL NOT BE PROCESSED.
- 7 THE GOVERNMENT OF MALAYSIA RESERVES THE RIGHT TO REJECT ANY APPLICATION:
 - a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; AND/OR
 - 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 PASSPORT 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 or 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. Hepatitis B					
3. Hepatitis C					
4. HIV					
5. Drugs use/abuse a. Opiates b. Methamphetamine c. Amphetamine d. Cannabinoids					
6. Congenital or Inherited Disorder					
7. Allergy					
8. Mental Illness					
9. Epilepsy					
10. Stroke / Neurological Disease					
11. Diabetes Mellitus					
12. Hypertension					
13. Heart or Vascular Disease					
14. Asthma					
15. Thyroid Disease					
16. Kidney Disease					
17. Cancer					
18. History of Surgery					
19. Sexually Transmitted Diseases					
20. History of Blood Transfusion					
21. 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)			

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 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.

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 PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

1. BASIC MEASUREMENT

HEIGHT (m) :	WEIGHT (kg)	BMI(kg/m ²)	PULSE RATE (PER MINUTE)	BLOOD PRESSURE: SYSTOLIC (mmHg) DIASTOLIC (mmHg)	
VISION TEST	NORMAL	DEFECTIVE		COLOUR VISION TEST	
UNAIDED (L)				COMMENT	
UNAIDED (R)					
AIDED (L)					
AIDED (R)					
HEARING ABILITY	NORMAL	DEFECTIVE		COMMENT	
LEFT					
RIGHT					

2. GENERAL EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
g. EYES (including funduscopy)			
h. EARS			
i. NOSE			
j. ORAL CAVITY / THROAT			
k. NECK			
l. CARDIOVASCULAR SYSTEM			
m. RESPIRATORY SYSTEM			
n. ABDOMEN/HERNIAL ORIFICES			
o. NERVOUS SYSTEM			
p. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

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

BLOOD TEST			
ITEM	POSITIVE / ABNORMAL	NEGATIVE / NORMAL	COMMENT
a. HEPATITIS B's ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
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. Hepatitis B	
3. Hepatitis C	
4. HIV	
5. Cancer	
6. Epilepsy	
7. Psychiatric Illness	
8. Drugs	
a. Opiates	
b. Methamphetamine	
c. Amphetamine	
d. Cannabinoids	
9. 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 : _____
 Official 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	
Tuberculosis			IF YOU HAVE SOUGHT CONSULTATION FOR ANY OF THE LISTED DISEASES/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.
Hepatitis B			
Hepatitis C			
HIV			
Drug use/abuse of:			
1. Opiates			
2. Cannabinoids			
3. Amphetamine			
4. Methamphetamine			
Sexually Transmitted Diseases			
Congenital or Inherited Disorder			
Cancer			
Epilepsy			
Psychiatric Illness			
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 **UNSUITABLE** 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 not 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 further 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