HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. PLEASE READ THE 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 **4 SECTIONS**:
   (a) SECTION 1 (PART A AND B) IS TO BE FILLED BY THE CANDIDATES
   (b) SECTION 2, 3 AND 4 IS TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY ACCEPTS MEDICAL EXAMINATION DONE WITHIN **60 DAYS** BEFORE REGISTRATION OR WITHIN **30 DAYS** AFTER REGISTRATION **IN MALAYSIA ONLY.**
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **CHEST X-RAY FILM AND REPORT** FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH).
10. CHEST X-RAY DONE WITHIN **6 MONTHS PRIOR** TO REGISTRATION CAN BE ACCEPTED.
11. 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 CANDIDATES.
12. THE UNIVERSITY HAS THE RIGHT TO **REJECT** ANY APPLICATION:
    (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION
    (b) IF THE APPLICANT HAS GIVEN 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 candidate)
(PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL STATUS
SINGLE
MARRIED

ACADEMIC YEAR
/

COURSE CODE

SEMESTER

FACULTY

MATRIC. NO

NEXT OF KIN

NEXT OF KIN'S ADDRESS

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. 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					

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 (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

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINE TYPE STIMULANTS		

* Please attach all the **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 the **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 him / her :-

☐ 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 :

Reff. No/ Matrik Number : ……………………..
Date : …………………….

CERTIFICATION BY EXAMINING DOCTOR

Name of Doctor :…………………………………………………………………………...........
Qualification : ………………………………………………………………………………….
Hospital / Clinic : ……………………………………………………………………………..
Registration Number : ……………………………………………………………………………..

To whom it may concern,

I hereby certify that Mr / Ms …………………………………………………….......................................
bearing Passport No …………………………………… redeemed **MEDICALLY FIT / UNFIT** to study in Malaysia in line with the mandatory guidelines regulated the Ministry of Education (MOE) Malaysia.

……………………………... ………………...

Signature of the Doctor **Date**

Official Stamp :