

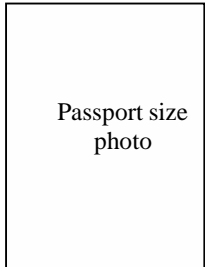
**HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS**

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) TO BE FILLED BY THE CANDIDATES; AND
 - (b) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE VALIDITY OF THIS MEDICAL EXAMINATION REPORT AND CHEST X-RAY IS WITHIN (6) MONTHS AFTER BEING SIGNED BY MEDICAL OFFICER.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG THE **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. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO **REPEAT** FULL MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
11. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO **REJECT** ANY APPLICATION:
 - (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
 - (b) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.



UNIVERSITI TUN HUSSEIN ONN MALAYSIA

HEALTH EXAMINATION REPORT



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 (DDMMYY)

AGE

Grid for age

SEX

Grid for sex (MALE/FEMALE)

MARITAL STATUS

Grid for marital status (SINGLE/MARRIED)

ACADEMIC YEAR SEMESTER

Grid for academic year and semester

COURSE CODE

Grid for course code

FACULTY

Grid for faculty name

STUDENT MATRIC NO.

Grid for student matric number

NEXT OF KIN

Grid for next of kin name

NEXT OF KIN' ADDRESS

Grid for next of kin address

NEXT OF KIN'S CONTACT NUMBER

Grid for next of kin contact number

SECTION 1**(PART B)** Please tick (3) 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					

Current medication (Long Term)

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

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 PRESURE : _____ mmHg
WEIGHT: _____kg	PULSE RATE : _____ / min
VISION TEST : Unrelated: (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. SYSTEMATIC 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. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION		
CHEST X-RAY NO.		
DATE TAKEN		
PLACE TAKEN		
REPORT		

Please tear here

SECTION 4 – CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (3) in the appropriate box.

I certify that I have on this date _____ examined

Mr. / Ms. _____ Passport No.

found him / her :-

IN GOOD HEALTH

HAS MEDICAL PROBLEMS (Please State)

IS UNDERGOING TREATMENT FOR: (Please State)

Date: _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification and : _____

Official stamp of clinic

Remarks by University Official: