



IIUM HEALTH AND WELLNESS CENTRE
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

HEALTH EXAMINATION GUIDELINES

FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

MALAYSIAN STUDENTS *Applicable to full-time students only*

1. All full-time students are required to undergo medical check-up at the recognized Government Hospitals/University Hospitals/Panel Clinics.
2. Please read the instructions carefully before filling in the form.
3. Please fill in the form in **English Language**.
4. Please write in **CAPITAL LETTERS**.
5. This form has five (5) sections:
 - a. part 1 and 2 to be filled by the student; and
 - b. part 3, 4 and 5 to be filled by the examining medical officer only.
6. Please bring along **chest x-ray film and report** on the registration day.
7. Please ensure the x-ray film is **labelled** with your name and date taken.
8. Chest x-ray done within **6 months prior** to registration can be accepted.
9. The university/college reserves the right to **repeat** full medical check-up or any specific laboratory tests. All costs involved shall be borne by the student.
10. The university/college reserves the right to **reject** any application or **cancel** any registration:
 - a. based on the results of the health examination; or
 - b. should there be any evidence that the student has given false information in the health examination report or any supporting documents.

INTERNATIONAL STUDENTS

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 four (4) sections:
 - a. section 1 (part a and b) to be filled by the student; 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 university/college only accepts medical examination done within **60 days** before registration or within **30 days** after registration
7. Please attach all the **ORIGINAL** laboratory results
8. Please bring along **chest x-ray film and report** on the registration day.
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/college reserves the right to **repeat** full medical check-up or any specific laboratory tests. All costs involved shall be borne by the student.
12. The university/college reserves the right to **reject** any application or **cancel** any registration:
 - a. based on the results of the health examination; or
 - b. should there be any evidence that the student has given false information in the health examination report or any supporting documents

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					

Current medication (Long term)

IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
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/ registration will be rejected/cancelled 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	WEIGHT : _____ kg
BLOOD PRESSURE : _____ mmHg	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.	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	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (v) in the appropriate box :

I certify that I have on this date _____ examined

Mr / Ms _____

Passport No. _____ and found him / her :-

IN GOOD HEALTH

HAVING THE FOLLOWING MEDICAL COMPLICATION (S) (Please State)

UNDERGOING TREATMENT FOR: (Please State)

.....
Signature of Doctor

.....
Date

Name of Doctor : _____

Qualification : _____

Hospital/Clinic : _____

Registration Number : _____

Official stamp : _____

REMARKS BY UNIVERSITY OFFICIAL:

PART 2 / BAHAGIAN 2

Please tick (/) in the relevant box / Sila tandakan (/) di kotak berkenaan

Declaration of self and immediate family (father, mother, siblings) illness. Explain in full if you or your family has any of the following illnesses. / Pengakuan mengenai penyakit yang dihadapi sendiri dan ahli keluarga terdekat (ibu, bapa, adik-beradik). Sila jelaskan dengan lanjut sekiranya anda atau ahli keluarga menghadapi penyakit-penyakit berikut:

NO.	MEDICAL PROBLEMS (Masalah Kesihatan)	SELF		IMMEDIATE FAMILY		If Yes, please state (Jika Ya, sila nyatakan)
		Yes	No	Yes	No	
1	Congenital or inherited disorder (Penyakit sejak lahir/ penyakit keturunan)					
2	Allergy (Alergi)					
3	Mental illness (Sakit jiwa)					
4	Fits, stroke, other neurological disease (Sawan, strok dan lain-lain penyakit saraf)					
5	Diabetes Mellitus (Kencing manis)					
6	Hypertension (Darah tinggi)					
7	Heart or vascular disease (Sakit jantung)					
8	Asthma (Lelah)					
9	Thyroid disease (Sakit tiroid)					
10	Kidney disease (Sakit buah pinggang)					
11	Cancer (Kanser)					
12	Tuberculosis (Batuk kering)					
13	Drug addiction (Penyalahgunaan dadah)					
14	AIDS, HIV					
15	Epilepsy (Gila babi)					
16	Deformity (Kecacatan)					
17	History of surgery (Sejarah pembedahan)					
18	Other illnesses (Lain-lain penyakit)					

I hereby certify that the information given above is true / Saya dengan ini mengaku segala maklumat kesihatan yang diberi di atas adalah benar

.....
Signature of candidate / Tandatangan calon

.....
Date / Tarikh

PART 3 / BAHAGIAN 3

TO BE FILLED BY EXAMINING DOCTOR / UNTUK DIISI OLEH DOKTOR YANG MEMERIKSA

Tick as relevant / Tandakan yang berkaitan /

1. GENERAL EXAMINATIONS / PEMERIKSAAN UMUM

HEIGHT / TINGGI cm/sm

WEIGHT / BERAT kilogram

PULSE / NADI per minute / seminit

BP / mmHg

a. PALLOR

b. CYANOSIS

c. OEDEMA

d. JAUNDICE

e. LYMPH NODES

f. SKIN

2. EXAMINATION OF EYE / PEMERIKSAAN MATA

RIGHT / KANAN

LEFT / KIRI

REMARKS / CATATAN

a. UNAIDED VISION / PENGLIHATAN TANPA KACA MATA

b. AIDED VISION / PENGLIHATAN DENGAN KACA MATA

c. FUNDOSCOPY
NORMAL
ABNORMAL

d. COLOUR VISION / PENGLIHATAN WARNA
NORMAL
ABNORMAL

3. EXAMINATION OF EAR / PEMERIKSAAN TELINGA

NORMAL
ABNORMAL

4. ORAL CAVITY / RUANG MULUT

NORMAL
ABNORMAL

5. HEART / JANTUNG

NORMAL
ABNORMAL

PART 5 / BAHAGIAN 5

CERTIFICATION BY DOCTOR / PENGESAHAN DOKTOR

Please tick (/) in the appropriate box / *Sila tandakan (/) di alam kotak yang berkenaan*

I certify that on this day I have examined / *Saya mengesahkan bahawa pada hari ini saya telah memeriksa*

_____ I.C. No. / No. K.P. _____

and found that : / *dan mendapati bahawa :*

The above named is in good health / *Beliau tidak menghidapi apa-apa penyakit dan disahkan sihat*

The above named has / *Beliau menghidapi* _____

The above named is undergoing treatment / *Beliau sedang mendapat rawatan* _____

Signature of Doctor : _____
Tandatangan Doktor

Date / *Tarikh* : _____

Name of Doctor : _____
Nama Doktor

Qualification / Official stamp of hospital / clinic :
Kelulusan dan Cop Rasmi Klinik:

REMARKS BY UNIVERSITY OFFICIAL: