

**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 APPLICANT; AND
 - b) SECTION 2,3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE THE ENTIRE TEST REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPT MEDICAL EXAMINATION DONE WITHIN **90 DAYS** BEFORE ARRIVAL IN MALAYSIA.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **CHEST X-RAY FILM (OR DIGITAL IMAGES) AND REPORT** FOR REGISTRATION, FOR THE PURPOSE OF VERIFICATION, IF NECESSARY.
9. PLEASE ENSURE THE X-RAY FILMS OR DIGITAL IMAGES ARE **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 SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED, ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. 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.

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

BLOOD GROUP (RHESUS)

NATIONALITY

CONTACT NUMBER IN MALAYSIA

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

ACADEMIC YEAR

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

The details of the blood type recorded here are as reported by the patient and have not been tested or verified to be correct by the medical practitioner completing this online medical screening questionnaire. 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.

EDUCATION MALAYSIA GLOBAL SERVICES (986610-U)

Education Malaysia One-Stop-Centre, 20th Floor, Menara TA One, 22, Jalan P.Ramlee, 50250 Kuala Lumpur, Malaysia
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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

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.

| MEDICAL PROBLEMS | SELF | | IMMEDIATE FAMILY | | If "Yes" please state details |
|---|------|----|------------------|----|-------------------------------|
| | 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. History of Surgery | | | | | |
| 13. Tuberculosis (TB) | | | | | |
| 14. HIV / AIDS | | | | | |
| 15. Hepatitis B | | | | | |
| 16. Sexually Transmitted Diseases | | | | | |
| 17. Drug Addiction | | | | | |
| 18. 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 :

- *A valid Yellow Fever vaccination certificate is required from all travellers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
- All students are required to take vaccines as listed in numbers 2-7 above.
- The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 2 - PHYSICAL EXAMINATION

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

EMGS REFERENCE NUMBER

1. BASIC MEASUREMENT

| | | | | | |
|------------------------|----------------------|-------------------------|--------------------------|----------------------|----------------------|
| HEIGHT (m) : | WEIGHT (kg) | BMI(kg/m ²) | PULSE RATE (PER MINUTE) | BLOOD PRESSURE: | |
| | | | | SYSTOLIC (mmHg) | DIASTOLIC (mmHg) |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| VISION TEST | NORMAL | DEFECTIVE | | | |
| UNAIDED (L) | <input type="text"/> | <input type="text"/> | COLOR VISION TEST | <input type="text"/> | |
| UNAIDED (R) | <input type="text"/> | <input type="text"/> | COMMENT | <input type="text"/> | |
| AIDED (L) | <input type="text"/> | <input type="text"/> | | | |
| AIDED (R) | <input type="text"/> | <input type="text"/> | | | |
| HEARING ABILITY | NORMAL | DEFECTIVE | COMMENT | | |
| LEFT | <input type="text"/> | <input type="text"/> | <input type="text"/> | | |
| RIGHT | <input type="text"/> | <input type="text"/> | <input type="text"/> | | |

2. GENERAL EXAMINATION

| ITEM | YES / ABNORMAL | NO / NORMAL | COMMENT |
|------------------|----------------------|----------------------|----------------------|
| a. DEFORMITIES | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| b. PALLOR | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| c. CYANOSIS | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| d. JAUNDICE | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| e. OEDEMA | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| f. SKIN DISEASES | <input type="text"/> | <input type="text"/> | <input type="text"/> |

3. SYSTEMIC EXAMINATION

| ITEM | NORMAL | ABNORMAL | COMMENT |
|--------------------------------|----------------------|----------------------|----------------------|
| g. EYES (including funduscopy) | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| h. EARS | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| i. NOSE | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| j. ORAL CAVITY / THROAT | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| k. NECK | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| l. CARDIOVASCULAR SYSTEM | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| m. RESPIRATORY SYSTEM | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| n. ABDOMEN/HERNIAL ORIFICES | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| o. NERVOUS SYSTEM | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| p. MENTAL STATUS | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| q. MUSCULOSKELETAL SYSTEM | <input type="text"/> | <input type="text"/> | <input type="text"/> |

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 2A - PHYSICAL EXAMINATION - EBOLA

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

EMGS REFERENCE NUMBER

Have you in the last 30 days travelled to or from the following Ebola affected countries:

| ITEM | YES | NO | COMMENT |
|-------------------------|-----|----|---------|
| Guinea | | | |
| Sierra Leone | | | |
| Liberia | | | |
| Nigeria | | | |
| Others (please specify) | | | |

Have you in the last 30 days come into contact with someone, who has in the last 30 days, traveled to or from the following Ebola affected countries:

| ITEM | YES | NO | COMMENT |
|-------------------------|-----|----|---------|
| Guinea | | | |
| Sierra Leone | | | |
| Liberia | | | |
| Nigeria | | | |
| Others (please specify) | | | |

Have you in the last 30 days come into contact with Ebola infected persons or animals?

| ITEM | YES | NO | COMMENT |
|--------|-----|----|---------|
| YES/NO | | | |

Do you have any of the following Ebola virus symptoms?

| ITEM | YES | NO | COMMENT |
|-------------------------------|-----|----|---------|
| Sudden onset of fever | | | |
| Intense weakness | | | |
| Myalgia | | | |
| Headache | | | |
| Sore Throat | | | |
| Vomiting | | | |
| Diarrhoea | | | |
| Rashes | | | |
| Haematuria | | | |
| Bloody Stool | | | |
| Internal or external bleeding | | | |
| Others (please specify) | | | |

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 3 - LABORATORY RESULTS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF LAB TEST

NAME OF LAB

URINE TEST

| ITEM | POSITIVE / ABNORMAL | NEGATIVE / NORMAL | 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 Bs ANTIGEN | | | |
| c. HIV | | | |
| d. VDRL | | | |
| d. TPHA | | | |
| e. MALARIAL PARASITES | | | |

* TPHA is done if VDRL is reactive

** all test results / reports is valid for 6 months

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 4 - CHEST X-RAY FINDINGS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF CHEST X-RAY

PLACE OF CHEST X-RAY

CHEST X-RAY NO.

COMMENT

| ITEM | NORMAL | ABNORMAL | COMMENT |
|--|--------|----------|---------|
| THORACIC CAGE | | | |
| HEART SHAPE AND SIZE (CTR IF APPLICABLE) | | | |
| LUNG FIELDS | | | |
| MEDIASTHNUM AND HILA | | | |
| PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES | | | |
| FOCAL LESION | | | |
| ANY OTHER ABNORMALITIES | | | |
| IMPRESSION | | | |

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

TYPE OF APPLICATION

DATE OF CERTIFICATION

| ITEM | ABNORMAL |
|-------------------------------------|----------|
| HIV | |
| HEPATITIS B | |
| TUBERCULOSIS | |
| MALARIA | |
| TYPHOID | |
| SEXUALLY TRANSMITTED DISEASES | |
| CANCER | |
| EPILEPSY | |
| PSYCHIATRIC ILLNESS | |
| HIS/HER URINE CONTAINS OPIATES | |
| HIS/HER URINE CONTAINS CANNABINOIDS | |
| HIS/HER URINE CONTAINS AMPHETAMINE | |
| EBOLA | |
| OTHERS | |
| | |

HEREBY THE STUDENT IS CERTIFIED AS

SUITABLE UNSUITABLE

FOR STUDY IN MALAYSIA.

COMMENT

NAME OF EXAMINING DOCTOR

QUALIFICATION OF EXAMINING DOCTOR

HOSPITAL/CLINIC REGISTRATION NUMBER

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