

FULL NAME (AS IN PASSPORT) & MATRIC NO.

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SECTION 1 (PART B) – Please tick (v) in the relevant box

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 father, mother, brothers / sisters*

MEDICAL PROBLEMS		SELF		IMMEDIATE FAMILY		If “Yes” please state.
		Yes	No	Yes	No	
1	Tuberculosis					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse a. Opiate b. Methamphetamine c. Amphetamine d. Cannabinoids					
6	Congenital or Inherited					
7	Drug 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 Disease					
20	History of Blood Transfusion					
21	Hospital Admission for Treatment of COVID-19 Positive					
22	Other Illnesses					

If you have sought consultation for any of the listed disease/condition, you are required to submit your medical history/report from your treating physician. I hereby certify that the information given above is true.

.....
Date

.....
Name of applicant as indicated in the passport

.....
Applicant’s Signature

.....
Applicant’s passport number

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IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
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/ registration will be rejected/cancelled if there is any false information given.

.....
Date

.....
Signature of candidate

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SECTION 2 - PHYSICAL EXAMINATION (To be filled by examining doctor)

1. BASIC MEASUREMENT	
HEIGHT : _____m	WEIGHT : _____kg BMI : _____kg/m ²
BLOOD PRESSURE Systolic : _____mmHg Diastolic : _____mmHg	PULSE RATE : _____/ min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL
HEARING ABILITY Left : NORMAL / ABNORMAL Right : NORMAL / ABNORMAL	COMMENT:

2. GENERAL EXAMINATION				
	ITEM	YES	NO	COMMENT
a.	DEFORMITIES			
b.	PALLOR			
c.	CYANOSIS			
d.	JAUNDICE			
e.	OEDEMA			
f.	SKIN DISEASES			

3. SYSTEMIC EXAMINATION				
	ITEM	YES	NO	COMMENT
a.	EYES (including funduscopic)			
b.	EARS			
c.	NOSE			
d.	ORAL CAVITY / THROAT			
e.	NECK			
f.	CARDIOVASCULAR SYSTEM			
g.	RESPIRATORY SYSTEM			
h.	ABDOMEN / HERNIA ORIFICES			
i.	NERVOUS SYSTEM			
j.	MUSCULOSKELETAL SYSTEM			

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4. MENTAL HEALTH ASSESSMENT**MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER**

A.	General Appearance		Neat & Tidy		Untidy	
B.	Speech Quality	Coherent	Yes		No	
		Relevant	Yes		No	
C.	Mood	Depressed*	Yes		No	
		Anxious	Yes		No	
		Irritable	Yes		No	
D.	Affect		Appropriate		Inappropriate	
E.	Thought					
	Delusion		Yes		No	
	Suicidity*		Yes		No	
F.	Perception					
	Hallucination		Yes		No	
G.	Orientation					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

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QUESTIONNAIRE (DECLARATION BY STUDENT)

PART A : MOOD		YES	NO
A.	Feeling depressed or low mood most of the day, nearly every day for the past 1 month; may be subjective (e.g. feels sad, empty, hopeless) or observed by others (e.g. appears tearful).		
B.	Markedly reduced interest/pleasure in all (or almost all) activities most of the day, nearly every day; may be subjective or observed by others.		
C.	Difficulty to sleep almost every night.		
If 'Yes' to question 1 or 2, to tick 'Yes' at DEPRESSED in assesement box.			

PART B : SUICIDALITY		YES	NO
A.	Feeling worthless or excessive/inappropriate guilt almost every day.		
B.	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or suicide attempt, or a specific plan for suicide.		
If 'Yes' to question 3 or , to tick 'Yes' at SUICIDALITY in assesement box.			

PART C : PSYCHOSIS		YES	NO
A.	Seeing image or hearing sounds that occurs (that you feel it is real) in the absence of an actual external stimulus observed by others.		
B.	Continuously believe that somebody is controlling your every move via radio waves or other methods.		
If 'Yes' to question 3 or, to tick 'Yes' at PSYCHOSIS in assessment box.			

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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.	AMPHETAMINES 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

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X-RAY REPORT

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

ITEM		NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
A.	THORACIC CAGE			
B.	HEART SHAPE & SIZE (CTR > 0.55 & IN FAILURE OR SIHNIFICANT CARDIOMEGALY			
C.	LUNG FIELDS			
D.	MEDIASTINUM & 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 (v) in the appropriate box:

I certify that I have on this date _____ examined

Mr / Ms _____

Passport No. _____ and found him / her with the following disease/condition:-

	ITEM	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:

.....
Signature of Doctor

.....
Date

Name of Doctor : _____

Qualification : _____

Hospital/Clinic : _____

Registration Number : _____

Official stamp : _____

HEALTH DECLARATION FORM FOR APPLICANTS

I declare that I will submit myself for compulsory Post-Arrival Health Examination as per Malaysian regulations. In the event that I should be diagnose 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 condition 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 Panel Clinic/University Health Centre harmless from any loss or liability arising from the decision and agree to indemnify and keep 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

CONSENT FORM FOR SEXUAL TRANSMITTED DISEASE (STD) SCREENING

Dear Doctor,

I,

Matric. No..... I/C No./Passport No..... hereby agree

on the blood test for STD screening and urine drug test at the IIUM Health and Wellness Centre.

Signature of Student:

Signature of Witness:

Name of Student:.....

Name of Witness:.....

I/C No./Passport No :.....

I/C No./Passport No :.....

Date :.....

Date :.....