IHWC-Clinic/V-03/R-02/ED-01092021

REGIONAL CENTRE OF EXPERTISE ON EDUCATION FOR SUSTAINABLE DEVELOPMENT

ACKNOWLEDGED BY

UNITED NATIONS UNIVERSITY

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

PASSPORT SIZE PHOTO
(not older than 6 months)

INSTRUCTION: PLEASE FILL IN USING CAPITAL LETTERS
SECTION 1(A) {sections 1 & 3(B) to be completed by the candidate**}**

FULL NAME (AS PER I. C. / PASSPORT)

I. C. / PASSPORT NO.

MOBILE PHONE NO.

NATIONALITY

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL STATUS
SINGLE
MARRIED
DIVORCED
WIDOWED

ACADEMIC YEAR
/

STUDENT ID (MATRIC NUMBER)

PROGRAMME OF STUDY

EMAIL ADDREESS

NAME OF THE NEXT OF KIN (CLOSEST LIVING RELATIVE)

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S MOBILE PHONE NO.

RELATION WITH THE NEXT OF KIN

FULL NAME (AS PER I. C. / PASSPORT) & MATRIC NO.

SECTION 1(B) – Please tick (√) the relevant box

Declaration of health status of self and immediate family (biologic parents & sibling). Explain in full if you have or anyone in the immediate family has any of the following medical problems/ conditions:

MEDICAL PROBLEMS/ CONDITIONS		SELF		IMMEDIATE FAMILY		IF 'YES' PLEASE EXPLAIN
		Yes	No	Yes	No	
1	Tuberculosis					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse:					
	Opiate					
	Methamphetamine					
	Amphetamine					
	Cannabinoids					
6	Congenital/ Inherited disorder(s)*					
7	Drug allergy					
8	Mental Illness(s)					
9	Neurological disorder(s)**					
10	Diabetes mellitus					
11	Hypertension (high blood pressure)					
12	Heart or vascular disease(s)					
13	Bronchial asthma					
14	Thyroid disorder(s)					
15	Kidney disorder(s)					
16	Cancer					
17	History of surgery					
18	Sexually transmitted disease(s)					
20	History of blood transfusion					
21	Hospitalization for COVID-19 treatment					
22	History of smoking					
22	Other Illness(es)					
23	**List of current medication(s)** {if any}					

*Medical conditions present since birth

** Neurological disorders include: Migraines, Epilepsy/ Seizures, Stroke, Motor neuron disease, Dementia/ Alzheimer's disease and Parkinson's disease

FULL NAME (AS PER I. C. / PASSPORT) & MATRIC NO.

SECTION 1(C}

IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
1	Yellow Fever*					
2	BCG					
3	Meningitis (Quadrivalent)					
4	Hepatitis B					
5	Polio					
6	Measles					
7	Rubella					
8	Covid-19 (include TYPE of vaccine e.g. Pfizer)					
9	Others: (Please specify)					

*A valid Yellow Fever vaccination certificate is required from all travelers coming from or having transited (more than 12 hours) through countries with risk of Yellow Fever transmission

The candidate is expected to have got vaccines listed in the above table at numbers 2-8

The candidate is required to bring along the International Certificate of Vaccination for verification of information

If you have sought consultation for any of the listed diseases/conditions at page 2, you are required to submit your medical history/report from your treating physician.

I hereby certify that the information given above is true. I also understand that my application/registration will be rejected/cancelled in case the information given was found untrue

…… ……..

Date **Name of the candidate as per I. C. / passport**

…….. ……..

Candidate's I. C. / Passport No. **Candidate's Signature**

FULL NAME (AS PER I. C. / PASSPORT) & MATRIC NO.

SECTION 2 - PHYSICAL EXAMINATION (Sections 2, 3A, 4 & 5 to be completed by the examining doctor)

1. BASIC MEASUREMENTS	
HEIGHT (CM):_____ WAIST CIRCUMFERENCE (CM):_____	WEIGHT (KG):_____ BMI (KG/M²):_____
BLOOD PRESSURE (mm Hg): Systolic:_____Diastolic:_____	PULSE RATE (beats/ 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		**PRESENT**	**ABSENT**	**COMMENT**
A	CYANOSIS			
B	DEFORMITIES			
C	JAUNDICE			
D	NAIL DISORDERS			
E	OEDEMA			
F	PALLOR			
G	SKIN DISEASES			

3. SYSTEMIC EXAMINATION				
ITEM		**NORMAL**	**ABNORMAL**	**COMMENT**
A	ABDOMEN			
B	CARDIOVASCULAR SYSTEM			
C	EARS			
D	EYES {including fundoscopy (if possible)}			
E	HERNIAL ORIFICES			
F	MUSCULOSKELETAL SYSTEM			
G	NECK			
H	NERVOUS SYSTEM			
I	NOSE			
J	ORAL CAVITY / THROAT			
K	RESPIRATORY SYSTEM			

FULL NAME (AS PER I. C. / PASSPORT) & MATRIC NO.

SECTION 3(A) - MENTAL HEALTH ASSESSMENT

(assessment by the examining doctor)

A	General appearance		Neat &tidy		Untidy	
B	Speechquality	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	
	Suicidality		Yes		No	
F	Perception:					
	Hallucination		Yes		No	
G	Orientation In:					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

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SECTION 3(B) - MENTAL HEALTH ASSESSMENT

{QUESTIONNAIRE} (declaration by the candidate)

1. MOOD		YES	NO
A	Feeling depressed or having low mood most of the days, 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 nearly all) activities most of the days, nearly every day, may be subjective or observed by others		
C	Difficulty sleeping almost every night		

2. 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		

3. PSYCHOSIS		YES	NO
A	Seeing images or hearing sounds that occurs (that you feel 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		

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SECTION 4 – INVESTIGATIONS

1. URINE TEST				
ITEM		**POSITIVE**	**NEGATIVE**	**COMMENT**
A	ALBUMIN			
B	SUGAR			
C	OPIATES (including codeine, morphine & heroin)			
D	CANNABINOIDS			
E	AMPHETAMINE TYPE STIMULANTS			
F	MICROSCOPIC EXAMINATION			

2. BLOOD TEST				
ITEM		**POSITIVE/ ABNORMAL**	**NEGATIVE/ NORMAL**	**COMMENT**
A	HEPATITIS B ANTIGEN			
B	HEPATITIS C ANTIBODY			
C	HIV ANTIBODY			
D	MALARIA PARASITES			
E	VDRL / TPHA*			

*TPHA will be done ONLY if VRDL found positive

FULL NAME (AS PER I. C. / PASSPORT) & MATRIC NO.

3. CHEST X-RAY:	
CHEST X-RAY FILM NO.	
DATE TAKEN	
PLACE TAKEN	

DOCTOR'S REPORT:

	ITEM	**NORMAL**	**ABNORMAL**	**DETAILS OF ABNORMALITY**
A	THORACIC CAGE			
B	HEART SHAPE & SIZE			
C	LUNG FIELDS			
D	MEDIASTINUM & HILAR REGION			
E	PLEURA /HEMIDIAPHRAGMS /COSTOPHRENIC ANGLES			
F	ANY OTHER ABNORMALITIES			
G	OVER ALL IMPRESSION			

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) the appropriate box:

It is certified that I have on this date _____examined

Mr. / Ms. _____I. C. / Passport/No._____

and found him / her with the following disease(s)/condition(s) as shown in the below table:

ITEM		YES	NO
1	Tuberculosis		
2	Hepatitis B		
3	Hepatitis C		
4	HIV		
5	Cancer		
6	Epilepsy		
7	Psychiatric Illness		
8	Drugs :		
	Opiates		
	Methamphetamine		
	Amphetamine		
	Cannabinoids		
9	Others (Please specify)		

IT IS HEREBY CERTIFIED THAT:

☐ The above name is in good health

☐ The above name has _____

☐ The above name is undergoing treatment for _____
with list of current medicines _____
_____

☐ The above named is unfit to study at IIUM

…… ……..

Signature of Doctor Date

Name of Doctor :_____

Official stamp :

HEALTH DECLARATION FORM

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 the candidate as per I. C. / passport**
…….	**……**
Candidate's signature	**Candidate's I. C. / passport number**

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES (STDs)/DRUGS SCREENING
BORANG PERSETUJUAN SARINGAN PENYAKIT KELAMIN/DADAH

MEDICAL OFFICER / *PEGAWAI PERUBATAN*,

I_____

Matric No. _____ I. C. / Passport No._____

hereby agree **to undergo STDs/ drugs screening** at the IIUM Health and Wellness Centre.

I fully understand the implications involved with the above-mentioned procedure.

*Saya*_____

*No. Matrik*_____*No. Kad Pengenalan/ No. Pasport*_____*dengan ini bersetuju untuk menjalani saringan penyakit kelamin/ dadah di Pusat Kesihatan & Kesejahteraan UIAM.*

Saya memahami sepenuhnya implikasi yang terlibat dengan prosedur di atas.

Signature of the candidate/*Tandatangan Calon*

_____

Name of the candidate /*Nama Calon*

_____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

_____

Date / *Tarikh*:_____

Signature of the witness/*Tandatangan Saksi*

_____

Name of the witness/*Nama Saksi*

_____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

_____

Date / *Tarikh:*_____