ISC(CFS)/V-03/R-04/ED-17052022

IIUM Sejahtera Clinic

PASSPORT SIZE PHOTOGRAPH (not older than 6 months)

GAMBAR SAIZ PASSPOT (tidak lebih daripada 6 bulan)

HEALTH EXAMINATION REPORT (MALAYSIAN STUDENT)
LAPORAN PEMERIKSAAN KESIHATAN (PELAJAR MALAYSIA)

INSTRUCTION: PLEASE READ CAREFULLY & FILL IN THE FORM IN CAPITAL LETTERS
ARAHAN: SILA BACA DENGAN TELITI & ISI BORANG MENGUNAKAN HURUF BESAR
{SECTIONS 1 & 3(B) to be filled in by the candidate}/ *{SEKSYEN 1 & 3(B) untuk diisi oleh calon}*

SECTION 1 (A) */ SEKSYEN 1 (A)*

FULL NAME (as per I. C.)/ *NAMA PENUH (seperti di dalam kad pengenalan)*

ACADEMIC YEAR */TAHUN AKADEMIK*

2	0			/	2	0		

MATRIC NO. */NO. MATRIK*

SEMESTER

IDENTITY CARD NO. */ NO. KAD PENGENALAN*

						-			-				

MOBILE PHONE NO. / NO. TELEFON BIMBIT

GENDER/JANTINA

Male/Lelaki ☐

Female/Perempuan ☐

MARITAL STATUS/STATUS PERKAHWINAN

Single/Bujang ☐ Divorced/Bercerai ☐

Married/Berkahwin ☐ Widowed/Balu ☐

ADDRESS/ALAMAT:

PERMANENT / *TETAP*	MAHALLAH ADDRESS/ALAMAT MAHALLAH

EMAIL: _____

NAME OF THE NEXT OF KIN (CLOSEST LIVING RELATIVE) / *NAMA SAUDARA TERDEKAT*

RELATION WITH THE NEXT OF KIN/*HUBUNGAN DENGAN SAUDARA*

NEXT OF KIN'S MOBILE PHONE NO./ *NO. TELEFON BIMBIT SAUDARA TERDEKAT*

NAME (as per I. C.) & MATRIC No./ *NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK*

SECTION 1 (B) – Please tick (/) the relevant box / *SEKSYEN 1 (B) – Sila tandakan (/) di kotak berkenaan*

Declaration of health status of self and immediate family (biologic parents & siblings). Explain in full if you have or anyone in the immediate family has any of the following medical problems/ conditions. / P*engakuan mengenai penyakit yang dihadapi sendiri atau ahli keluarga terdekat (ibu, bapa dan adik-beradik). Sila jelaskan dengan lanjut sekiranya anda atau ahli keluarga terdekat menghidapi penyakit-penyakit berikut:*

	LIST OF MEDICAL PROBLEMS /CONDITIONS *(SENARAI PENYAKIT)*	**SELF / *SENDIRI***		**IMMEDIATE FAMILY / *AHLI KELUARGA TERDEKAT***		**IF 'YES' PLEASE EXPLAIN/ *SILA JELASKAN JIKA 'YA'***
		Yes */ya*	**No / *tiada***	**Yes */ya***	**No */tiada***	
1	Tuberculosis/ B*atuk Kering*					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse/ *dadah:*					
	Opiate					
	Methamphetamine					
	Amphetamine					
	Cannabinoids					
6	Congenital/ Inherited disorder(s)*/ *Penyakit kongenit/ keturunan*					
7	Drug allergy/ A*lahan ubat*					
8	Mental Illness(es*)/ Penyakit mental*					
9	Neurological disorder(s*)/Penyakit Saraf***					
10	Diabetes mellitus/ K*encing Manis*					
11	Hypertension/ D*arahTinggi*					
12	Heart or vascular disease(s)/ P*enyakit jantung*					
13	Bronchial asthma*/ Lelah*					
14	Thyroid disorder(s)/ Penyakit Tiroid					
15	Kidney disorder(s*)/ P*enyakit buah pinggang*					
16	Cancer/ B*arah*					
17	History of surgery/ S*ejarah pembedahan*					
18	Sexually transmitted disease(s)/P*enyakit kelamin*					
19	History of blood transfusion*/ Sejarah tranfusi darah*					
20	Hospitalization for covid-19 treatment*/ Kemasukan ke hospital untuk rawatan covid-19*					
21	History of smoking*/ Sejarah merokok*					
22	Other Illness(es)/ L*ain-lain penyakit*					
23	List of current medication(s) {(if any)/ S*enarai ubat-ubatan terkini (jikaada)}*					

*Medical conditions present since birth/ penyakit kongenit/ keturunan. ** Neurological disorders include: Migraines, Epilepsy/ Seizures, Stroke, Motor neuron disease, Dementia/ Alzheimer's disease and Parkinson's disease*/ (Gangguan neurologi termasuk: Migrain, Sawan / Kejang, Strok,Penyakit motor neuron, penyakit dementia / Alzheimer dan penyakit parkinson*

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

SECTION 1 (C)/ **SEKSYEN 1 (C)**

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

*A valid Yellow Fever vaccination certificate is mandatory for all travellers coming from or having transited (more than 12 hours) through countries with risk of Yellow Fever transmission. / *Sijil Vaksinasi Demam Kuning yang sah adalah diwajibkan bagi pelancong yang tiba atau transit (lebih dari 12 jam) melalui negara-negara dengan risiko penularan Demam Kuning*

The candidate is expected to have taken vaccines listed in the above table(numbers2-8)**/***Calon diharapkan mengambil vaksin yang tertera di jadual di atas (nombor2-8)*

The candidate is required to bring along the International Certificate of Vaccination for verification of information/ *Calon dikehendaki membawa Sijil Vaksinasi Antarabangsa untuk pengesahan maklumat*

If you have sought consultation for any of the listed conditions on page 2, you are required to submit your medical report from your attending doctor. */ Jika anda pernah mendapatkan rawatan untuk sebarang masalah di surat muka 2, sila kemukakan laporan perubatan dari doktor yang merawat anda*

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/ ***Dengan ini saya mengesahkan bahawa maklumat yang diberikan diatas adalah benar. Saya juga memahami bahawa permohonan/ pendaftaran saya akan ditolak/ dibatalkan sekiranya maklumat yang diberikan didapati tidak benar***

Date/*Tarikh*

Name of the candidate as per I. C. /*Nama calon seperti di dalam kad pengenalan*

Candidate's I.C. No./No Kad Pengenalan Calon

Candidate's signature/ ***Tandatangan Calon***

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

SECTION 2 - PHYSICAL EXAMINATION(Sections 2, 3A, 4 & 5 to be completed

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
1	Cyanosis			
2	Deformities			
3	Jaundice			
4	Nail Disorders			
5	Oedema			
6	Pallor			
7	Skin Diseases			

3. SYSTEMIC EXAMINATION

	ITEM	NORMAL	ABNORMAL	COMMENT
1	Abdomen			
2	Cardiovascular System			
3	Ears			
4	Eyes {Including Fundoscopy (If Possible)}			
5	Hernial Orifices			
6	Musculoskeletal System			
7	Neck			
8	Nervous System			
9	Nose			
10	Oral Cavity / Throat			
11	Respiratory System			

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

SECTION 3 (A) - MENTAL HEALTH ASSESSMENT (Assessment by the examining doctor)

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	
	Suicidality		Yes		No	
f	Perception:					
	Hallucination		Yes		No	
g	Orientation In:					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

SECTION 3 (B) - MENTAL HEALTH ASSESSMENT (Declaration by the candidate)

1. MOOD		**YES**	**NO**
a.	Feeling depressed or having low mood most of the day, nearly every day for the past 1month, maybe 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, maybe 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		

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

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	VDRL/ TPHA*			

* TPHA will be done only if VDRL test found positive

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

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/Hemi diaphragms/ Costophrenic angles			
f	Any other abnormalities			
g	Over All Impression			

Please note: CHEST X-RAY IS NOT MANDATORY FOR MALAYSIAN STUDENTS ***(Harap maklum: X-Ray dada tiada wajib untuk pelajar pelajar Malaysia)***

*To be done by the ISC if indicated at additional cost *(X-Ray dada akan dilakukan oleh ISC jika perlu dengan kos tambahan*)

NAME (as per I. C.) & MATRIC No./ *NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK*

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) the appropriate box:

I certify to 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:

ITEMS		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 the Doctor **Date**

Name of the Doctor: _____
Official Stamp:

NAME (as per I. C.) & MATRIC No./ *NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK*

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

I, _____

Matric No._____ I.C.No._____

hereby agree to undergo STDs/ drugs screening at the IIUM Sejahtera Clinic. I fully understand the implications involved with the above-mentioned procedure.

Saya, _____

*No. Matrik*_____ *No. Kad Pengenalan* _____

Dengan ini bersetuju untuk menjalani saringan penyakit kelamin/dadah di IIUM Sejahtera Clinic. Saya memahami sepenuhnya implikasi yang terlibat dengan prosedur di atas.

Signature of the candidate/*Tandatangan calon*	**Signature of the witness /*Tandatangan saksi***
Name of the candidate/*Nama calon*	**Name of the witness /*Nama saksi***
I.C. No. of the candidate / *No. Kad Pengenalan calon*	**I.C. No. of the witness / *No. Kad Pengenalan saksi***
Date/Tarikh	**Date/Tarikh**

NAME (as per I. C.) & MATRIC No./ ***NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK***

Please note: This page is to be signed by parent/ guardian of the student below 18 years of age
Harap maklum : Halaman ini hendaklah ditandatangani oleh ibu bapa/penjaga pelajar di bawah umur 18 tahun

AUTHORIZATION FOR ANESTHESIA AND SURGICAL PROCEDURE
(PERAKUAN KEBENARAN BIUS (ANESTHESIA) DAN PEMBEDAHAN

MEDICAL OFFICER/*PEGAWAI PERUBATAN*
IIUM Sejahtera Clinic
International Islamic University Malaysia/ *Universiti Islam Antarabangsa Malaysia*
Jalan Gombak, 53100 Kuala Lumpur

I _____NRIC No._____

Father/ mother/ guardian of (name of the student) _____

hereby authorize the Medical Officer to sign on my behalf for anaesthesia or carry out a surgical procedure on the applicant in my absence in the event of an emergency as confirmed by the attending doctor, when required.

Saya_____ No. K/P _____

bapa/ ibu/ penjaga kepada (nama pelajar) _____

dengan ini memberi kuasa kepada tuan menandatangani kebenaran bagi pihak saya, jika pada pandangan doktor yang pelajar ini memerlukan rawatan bius (anesthesia) atau pembedahan,sedangkan saya tidak dapat hadir pada masa yang diperlukan.

I will absolve the International Islamic University Malaysia of any claims or responsibilities from any unfavourable consequences arising from the said procedure.

Saya tidak akan mendakwa atau mengambil sebarang tindakan terhadap Universiti Islam Antarabangsa Malaysia jika berlaku sebarang kemungkinan yang timbul daripada prosedur tersebut.

Yours faithfully,

Yang benar,

_____ _____

Name of Father/ Mother/ Guardian
Nama Bapa/ Ibu/ Penjaga

Signature of Father/Mother/ Guardian
Tandatangan Bapa/Ibu/Penjaga

Address/*Alamat:* _____

_____

Tel. No./*Nombor telefon:* _____

Date/Tarikh: _____