



HEALTH EXAMINATION REPORT (INTERNATIONAL STUDENT)

PASSPORT
SIZE
PHOTOGRAPH
(not older than
6 months)

INSTRUCTION: PLEASE READ CAREFULLY & FILL IN THE FORM IN CAPITAL LETTERS
{SECTIONS 1 & 3(B) to be filled in by the candidate}

SECTION 1 (A)

FULL NAME (as per passport)

PASSPORT NO.

LOCAL PHONE NO. (MOBILE PHONE)

NATIONALITY

DATE OF BIRTH

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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D D M M Y Y

GENDER

Male

Female

MARITAL STATUS

Single Divorced

Married Widowed

ACADEMIC YEAR

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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STUDENT ID (MATRIC NO.)

PROGRAMME OF STUDY

EMAIL ADDRESS

NAME OF THE NEXT OF KIN (CLOSEST LIVING RELATIVE)

NEXT OF KIN'S ADDRESS

RELATION WITH THE NEXT OF KIN

NEXT OF KIN'S MOBILE PHONE NO.

NAME (AS PER PASSPORT) & MATRIC NO.

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SECTION 1(B) – Please tick (/) in the relevant box.

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

LIST OF 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(es)						
9	Neurological disorder(s)						
10	Diabetes mellitus						
11	Hypertension						
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)						
19	History of blood transfusion						
20	Hospitalization for covid-19 treatment						
21	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

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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 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.

The candidate is expected to have taken vaccines listed in the above table (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 conditions on page 2, you are required to submit your medical report from your attending doctor.

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 passport

Candidate's passport no.

Candidate's signature

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

1. BASIC MEASUREMENTS	
Height (cm): _____ Waist Circumference (cm): _____	Weight (Kg): _____ BMI (Kg/M ²): _____
Blood pressure (mm Hg): Systolic: _____ Diastolic: _____	Pulse rate (beats/min): _____
Vision test: Unaided:(R) ____ / ____ (L) ____ / ____ Aided:(R) ____ / ____ (L) ____ / ____	Colour Vision Test: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Hearing ability: Left : Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Right: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Comments:

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	Hernia orifices			
f	Musculoskeletal system			
g	Neck			
h	Nervous System			
i	Nose			
j	Oral cavity/Throat			
k	Respiratory System			

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

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	

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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		

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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 VDRL test found positive

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SECTION 4: INVESTIGATIONS

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			

NAME (AS PER PASSPORT) & MATRIC NO.

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (v) the appropriate box:

I certify to have on this date _____ examined Mr. /Ms.

_____ 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 PASSPORT) & MATRIC NO.

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 dead line 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 what so ever, 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 indemnity if and keep Panel Clinic/ University Health Centre from any loss or liability arising from this decision.

Date

Name of the Candidate as Per Passport

Candidate's Signature

Candidate's Passport Number

NAME (AS PER PASSPORT) & MATRIC NO.

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES (STDs)/DRUGS SCREENING

I, _____

Matric No. _____ Passport No. _____

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

Signature of the Candidate

Signature of the Witness

Name of the Candidate

Name of the Witness

Passport No. of the Candidate

Passport No. of the Witness

Date

Date