IIUM Sejahtera Clinic

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

D D M M Y Y

GENDER

Male ☐ Female ☐

MARITAL STATUS

Single ☐ Married ☐ Divorced ☐ Widowed ☐

ACADEMIC YEAR

2 0 _ _ / 2 0 _ _

STUDENT ID (MATRIC NO.)

PROGRAMME OF STUDY

EMAIL ADDRESS

KULLIYYAH

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.

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

NAME (AS PER 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, Mumps and Rubella					
7	Covid -19 (include vaccine TYPE, e.g. Pfizer, Astra Zeneca, Sinovac)					
8	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**

NAME (AS PER PASSPORT) & MATRIC NO.

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

1. BASIC MEASUREMENTS	
Height (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	Hernia orifices			
f	Musculoskeletal system			
g	Neck			
h	Nervous System			
i	Nose			
j	Oral cavity/Throat			
k	Respiratory System			

NAME (AS PER PASSPORT) & MATRIC NO.

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 PASSPORT) & MATRIC NO.

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 PASSPORT) & MATRIC NO.

SECTION 4: INVESTIGATIONS

1. URINE TEST				
ITEM		**POSITIVE**	**NEGATIVE**	**COMMENT**
a	Albumin			
b	Sugar			
c	Opiate (Including Codeine, Morphine & Heroin)			
d	Cannabinoids			
e	Amphetamines Type			

2. BLOOD TEST				
ITEM		**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a	Hepatitis B Antigen			
b	Hepatitis C Antibody			
c	HIV Antibody			
d	Malaria Parasite			
e	VDRL / TPHA*			

* TPHA is done if VRDL is reactive
* Full details of blood test results are **MANDATORY** to be enclosed with this form.

NAME (AS PER 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/Hemi diaphragms/ Costophrenic angles			
f	Any other abnormalities			
g	Over All Impression			

NAME (AS PER PASSPORT) & MATRIC NO.

IT IS HEREBY CERTIFIED THAT:

☐ The above named is in good health

☐ The above named has unsatisfactory Medical Check Up outcome

☐ The above named has the following medical condition(s):

1. _____
2. _____
3. _____
4. _____

☐ The above named is on following medication(s):

1. _____
2. _____
3. _____
4. _____

_____ _____

Signature of the Doctor **Date**

Name of the Doctor: _____
Official Stamp:

Verification by the ISC Medical Officer/ Physician (If Medical Check-Up done at any place other than ISC/FHC)

☐ Fit to study

☐ Unsatisfactory Medical Check Up outcome

_____ _____

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**