GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT

1. PLEASE READ THIS INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM
2. PLEASE FILL IN THE FORM IN ENGLISH LANGUAGE
3. PLEASE WRITE IN CAPITAL LETTERS
4. THIS FORM HAS 2 SECTIONS
   - SECTION 1 (PART A & B) TO BE FILLED BY THE CANDIDATES
   - SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TEST REQUIRED IN THIS FORM
6. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS AND THE RESULTS MUST BE REPORTED IN ENGLISH. IT MUST BE DONE WITHIN 2 MONTHS PRIOR TO REGISTRATION
7. PLEASE BRING ALONG THE CHEST X-RAY FILM AND REPORT
   a. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (**IN ENGLISH**)
   b. CHEST X-RAY MUST BE DONE **WITHIN 6 MONTHS** PRIOR TO REGISTRATION
8. UNIVERSITY HEALTH CENTRE CONCERNED HAS THE RIGHT TO **REPEAT** THE MEDICAL CHECK-UP SHOULD THERE BE ANY DOUBT OF THE MEDICAL REPORT. ALL COST INVOLVED WILL BE PAID BY THE CANDIDATES
9. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION:
   a. BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
   b. SHOULD THERE BE ANT EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

Terms and regulation for Health-related Disorder for Admission of International Students by Malaysia's Ministry of Higher Education.

1. Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
• Contagious • Recover is expected to be difficult and delayed	• HIV/AIDS • Hepatitis B • Hepatitis C	• Registration / admission is prohibited
• Contagious • Expected to recover with treatment	• Tuberculosis	• Registration / admission is must be deferred until treatment in home country is completed • Deferment should not be for more than two semester • Registration requires confirmation from the physician in charge that treatment has been completed
• Contagious • Expected to recover with treatment	• Malaria • Typhoid • Syphilis	• Registration / admission is allowed only after treatment is completed in home country
• Contagious disease that are declared as epidemic by the Malaysian Ministy of Health	• Japanese Encephalitis • SARS • Avian Flu	• Registration / admission is prohibited

2. Non – Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
• An attack that may harm the student or other	• Epilepsy • Schizophrenia	A report is required from the treating specialist. May be accepted for registration / admission if any of the following is met: • Symptom-free for ›12 months • Treatment is completed
• Disease or disorder is expected to continue for an unspecified time • Apparent and serious symptoms • Long treatment schedule	• End stage renal failure requiring dialysis • Canser	• Registration / admission is prohibited
• Addiction that is direct violation of the Malaysia laws	• Drugs • Morphine • Canabis • Ampethamine • Metampethamine	• Registration / admission is prohibited
• Requires continuous medication • No serious symptoms • Treatment not affecting study	• Hypertension • Diabetes Mellitus	• May register if treatment does not affect study

Universiti Malaysia KELANTAN

MINISTRY OF HIGHER EDUCATION

HEALTH EXAMINATION REPORT
UNIVERSITI MALAYSIA KELANTAN

Passport size photo

PLEASE USE CAPITAL LETTERS
SECTION 1 (To be completed by candidate)
(PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH

D D M M Y Y

AGE

SEX

MALE
FEMALE

MARITAL STATUS

SINGLE
MARRIED

ACADEMIC YEAR

/

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

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

Declaration of self and family illness. Explain in full if you or your 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. AIDS,HIV					
2. Hepatitis B/C					
3. Congenital or inherited disorder					
4. Allergy					
5. Mental liness					
6. Fits,stroke,other neurological disease					
7. Diabetes Mellitus					
8. Hypertension					
9. Heart or vascular disease					
10. Asthma					
11. Thyroid disease					
12. Kidney disease					
13. Cancer					
14. Tuberculosis					
15. Drug addiction					
16. History of surgery					
17. Other Illnesses					

Current medication (Long term)

____

____

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZAD				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true understand that my application will be rejected if there is any false information given.

....

Date Signature of candidate

SECTION 2 – PHYSICAL EXAMINATION
To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : ___________________________ m	BLOOD PRESSURE : _________________ mmHg
WEIGHT : ___________________________ kg	PULSE RATE : _________________ / min
VISION TEST : Unaided : (R) __________ (L) _______________ Aided : (R) __________ (L) _______________	COLOR VISION TEST : NORMAL / ABNORMAL

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

3. SYSTEMIC EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including funduscopy)			
B. EARS			
C. NOSE			
d. ORAL CAVITY/THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN/HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 – INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
URINE FEME		
URINE DRUG * (*completed by UMK Medical Officer) a) Morphine b) Canabis c) Ampethamine d) Metampethamine		

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

SECTION 4 – CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (□) in the appropriate box

I certify that I have on this date ______________________ examined
Mr /Ms ____ Passport No. _______________________
And found him/her:-

☐ IN GOOD HEALTH

☐ HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)

____

____

____

☐ UNDERGOING TREATMENT FOR: (Please State)

____

____

____

Date ____________________

Signature of Doctor	:	___________________________
Name of Doctor	:	___________________________
Qualification	:	___________________________
Hospital / Clinic	:	___________________________
Registration Number		
Official stamp	:	___________________________

____

Remarks By UMK Medical Officer :

Lampiran B

Carta Alir Pemeriksaa Kesihatan Pelajar Antarabangsa di IPT Malaysia