PUSAT KESIHATAN UNIVERSITI
Universiti Malaysia Perlis, Kampus Pauh Putra, 02600 Arau, Perlis, Malaysia
Tel : +604 9885068 Fax : +6049885389

HEALTH EXAMINATION GUIDELINE

FOR ENTRY INTO

MALAYSIAN HIGHER EDUCATION INSTITUTIONS

1 ALL APPLICANTS **SHALL** UNDERGO HEALTH EXAMINATION WITHIN SEVEN (7) WORKING DAYS UPON ARRIVAL IN MALAYSIA.

2 FAILURE IN COMPLYING WITH THE ABOVE MATTER WILL RESULT IN REJECTION OF APPLICATION FOR STUDENT PASS.

3 APPLICANTS ARE REQUIRED TO UNDERGO HEALTH EXAMINATION ONLY AT HEALTH CENTRE OF UNIVERSITI MALAYSIA PERLIS (UniMAP).

4 PLEASE FILL IN THE FORM IN **ENGLISH** AND WRITE IN **CAPITAL LETTERS**.

5 IF THE APPLICANTS FAILED THE HEALTH EXAMINATION, STUDENT PASS ENDORSEMENT WILL NOT BE PROCESSED AND THE APPLICANT IS REQUIRED TO LEAVE MALAYSIA.

6 APPLICANTS WHO FAILED THE HEALTH EXAMINATION **MAY** SUBMIT THEIR APPEAL APPLICATION WITHIN THREE (3) WOARKING DAYS AFTER RECEIVING HEALTH EXAMINATION RESULT. ANY APPLICATION SUBMITTED AFTER THE STIPULATED PERIOD WILL NOT BE PROCESSED.

7 UNIVERSITI MALAYSIA PERLIS (UniMAP) RESERVES THE RIGHT TO REJECT ANY APPLICATION :

a) BASE ON THE RESULTS OF THE HEALTH EXAMINTION ; AND/OR
b) SHOULD THERE BE ANY EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION PERTAINING TO THE RESULTS OF THE HEALTH EXAMINATION.

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SECTION 1

FOREIGN STUDENT / DEPENDENT CONSENT, AUTHORISATION AND DECLARATION FORM

This is to confirm that I, _____
(Name of Foreign Student / Dependent as in passport)

Passport Number _____ Matric Number _____

hereby irrevocably consent and authorize Dr. _____
(Doctor's Name)

of Pusat Kesihatan Universiti, Universiti Malaysia Perlis to :
(Name of clinic)

i. Carry out a medical examination on me including the testing of blood and urine and the taking of chest x-ray in compliance with the Education Malaysia Global Services' ("EMGS") medical screening requirements ; and

ii. Disclose my health report / records and any other health information to EMGS, the Ministry of High Education, the Ministry of Health, the Immigration Department of Malaysia and any other relevant authorities, as and when it is required to do so.

I also hereby confirm the following :

i. I have not taken / taken * (if taken, please specify) any medication / drugs within the last two (2) weeks; and

   (a)_____(b)_____ (c)_____

ii. My last menstrual period was on _____ /_____ /_____ (DD/MM/YY) (FEMALES ONLY)

_____ _____
Signature or thumbprint of Foreign Student / Dependent Date

Witness by :

_____ _____
Signature of Examining Doctor **Name of Examining Doctor**

_____
Clinic's Stamp

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SECTION 2

Reference No :

LETTER OF UNDERTAKING

To : Universiti Malaysia Perlis
Date : _____

Student Name / Dependent Name : _____

Passport Number : _____ Country of Origin : _____

Matric Number : _____

Correspondence Address : _____

_____

Telephone Number : (H) : _____ (H/P) : _____

I declare that I will submit myself for compulsory Post-Arrival Health Examination as per Malaysian regulations. In the event that I should be diagnosed 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 required 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 EMGS Panel Clinic/ University Health Centre harmless from any loss or liability arising from this decision and agree to indemnify and keep EMGS Panel Clinic/ University Health Centre from any loss or liability arising from this decision.

_____ _____
Name of Student (as in passport) Signature of Student

_____
Signature of Dependent

Witness by :

_____ _____
Name of Examining Doctor Signature of Examining Doctor

_____
Clinic Stamp

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON
IMPORTANT : PLEASE USE CAPITAL LETTERS AND TICK (✓) WHERE APPROPRIATE

Passport size photo (compulsory)

SECTION 3
(To be completed by APPLICANT and all fields are ***MANDATORY)***

(PART A) **DATE OF MEDICAL EXAMINATION** D D M M Y Y

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

NATIONALITY

COUNTRY OF RESIDENCE

DATE OF BIRTH D D M M Y Y

AGE

SEX

MALE	
FEMALE	

MARITAL STATUS

SINGLE	
MARRIED	

BLOOD GROUP

A	B	AB	O

RHESUS

NEGATIVE	POSITIVE

CONTACT NUMBER IN MALAYSIA

ACADEMIC YEAR

MATRIC NUMBER

PROGRAMME OF STUDY

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

DATE OF ARRIVAL IN MALAYSIA D D M M Y Y

The details of blood type recorded here are as reported by the patient and have not been tested or verified to be correct by the medical practitioner completing this online medical screening questionnaire. The medical practitioner completing this from disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering or loss caused by any reliance on this information by any other party.

NAME :_____

PASSPORT NUMBER : _____

SECTION 3

(PART B) – Please tick (✓) in the relevant box.

Declaration of self and family illness. Explain in full if you or your immediate family* has any of the following illnesses.

*Immediate family refer to father, mother, brother/sister

MEDICAL HISTORY	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Congenital or Inherited Disorder					
2. Allergy					
3. Mental Illness					
4. Epilepsy					
5. Strokes / Neurological Disease					
6. Diabetes Mellitus					
7. Hypertension					
8. Heart or Vascular Disease					
9. Asthma					
10. Thyroid Disease					
11. Kidney Disease					
12. Cancer					
13. History of Surgery					
14. Tuberculosis (TB)					
15. Drug Addiction					
16. HIV / AIDS					
17. Hepatitis B					
18. Hepatitis C					
19. Sexually Transmitted Diseases					
20. Color Blindness					
21. History of Blood Transfusion					
22. Other Illnesses _____ _____					

If on any medication, please state below :

_____

_____

	VACCINAION HISTORY (where applicable)	Yes	No	Date of Vaccination
1.	Yellow Fever			
2.	BCG			
3.	Meningitis (Quadrivalent)			
4.	Hepatitis B			
5.	Polio			
6.	Measles			
7.	Rubella			
8.	Other (specify)			

Notes:

1. *A valid yellow fever vaccination certificated is required from all travelers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.*
2. *All students are required to take vaccines as listed in number 2-7 above.*
3. *The student are required to bring along the International Certificated of Vaccination or Prophylaxis with them for verification of information*

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

Name of Student / Dependent as in passport : _____

Signature : _____ Date : _____

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 3 – PHYSICAL EXAMINATION
PART C
(To be completed by EXAMINING DOCTOR)

* Has the Consent Letter been signed by the foreign student/dependent ? YES / NO * delete as appropriate

* Has the Letter of Undertaking been signed by the foreign student/dependent ? YES / NO * delete as appropriate

1. GENERAL EXAMINATION		
HEIGHT : m	**BLOOD PRESSURE**	**PULSE RATE** :
WEIGHT : kg	SYSTOLIC : mmHg	per minute
BMI :	DIASTOLIC : mmHg	

VISION TEST :

		Normal	Defective
Unaided	Left		
	Right		
Aided	Left		
	Right		

COLOUR VISION TEST :

NORMAL / ABNORMAL

COMMENT :

HEARING ABILITY :

	Normal	Defective	COMMENT
Left			
Right			

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

3. SYSTEMIC EXAMINATION				
ITEM		**NORMAL**	**ABNORMAL**	**COMMENT**
a.	EYES (including fundoscopy)			
b.	EARS / HEARING ABILITY			
c.	NOSE			
d.	ORAL CAVITY / THROAT			
e.	NECK			
f.	CARDIOVASCULAR SYSTEM			
g.	RESPIRATORY SYSTEM			
h.	ABDOMEN / HERNIA ORIFICES			
i.	NERVOUS SYSTEM			
j.	MUSCULOSKELETAL SYSTEM			
k.	LYMPH NODE ENLARGEMENT			
l.	GENITOURINARY SYSTEM			
m.	MENTAL STATUS			

NAME :_____

PASSPORT NUMBER : _____

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

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					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

***Note : Refer to Questionnaire**

If "Yes" for any of item C,E,F or G, to certify as UNSUITABLE.

QUESTIONNAIRE

PART A : MOOD					
1.	During the past month, have you been feeling down / depressed for most of the day	Yes		No	
2.	During the past month, have you loss interest in doing things that you like for most of the days?	Yes		No	

If "Yes" to question 1 or 2, to tick "yes" at DEPRESSED in assessment box.

PART B : SUICIDALITY					
3.	Do you feel that life is not worth living?	Yes		No	
4.	Do you have any thoughts about ending your life?	Yes		No	

If "Yes" to question 3 or 4, to tick "yes" at SUICIDALITY in assessment box.

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 4 – LABORATORY RESULT
(To be completed by EXAMINING DOCTOR)

NAME OF LABORATORY

_____

URINE TEST				
ITEM		**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a.	ALBUMIN			
b.	SUGAR			
c.	OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN)			
d.	CANNABINOIDS			
e.	AMPHETAMINE-TYPE STIMULANT			

BLOOD TEST				
ITEM		**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a.	HEPATITIS B SURFACE ANTIGEN			
b.	HEPATITIS C ANTIBODY			
c.	HIV			
d.	VDRL / *TPHA			
e.	MALARIA PARASITE			

*TPHA is done if VDRL is reactive
**all test result / report is valid for 90 days.

DATE OF LAB TEST

_____

_____
Signature of Lab Technologist

_____ _____
Name of Lab Technologist Official Stamp

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 5 – CHEST X-RAY REPORT

NAME OF X-RAY DEPARTMENT

_____

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
Comments (if any)	

_____

Signature of Radiographer

_____

Name of Radiographer

DESCRIPTION	**NORMAL**	**ABNORMAL**	**DETAILS OF ABNORMALITY**
1. Thoracic cage			
2. Heart shape and size (CTR if applicable)			
3. Lung fields			
4. Mediastinum and hila			
5. Pleura/Hemidiaphragms/Costophrenic Angles			
6. Focal Lesion (e.g old/new PTB, malignancy)			
7. Any other abnormalities			
8. Impression			
9. Comment			

_____

Signature of Medical Officer

_____ _____

Name of Medical Officer Official Stamp

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 6 – 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 with the following disease/condition:

ITEM	ABNORMAL
PHYSICAL EXAMINATION	
TUBERCULOSIS	
HIV	
HEPATITIS B	
HEPATITIS C	
CANCER	
EPILEPSY	
SEXUALLY TRANSMITTED DISEASES	
URINE FOR AMPHETAMINE TYPE STIMULANTS (ATS)(SCREENING TEST)	
URINE FOR OPIATES (SCREENING TEST)	
URINE FOR CANNABINOIDS (SCREENING TEST)	
OTHER (PLEASE SPECIFY) _____ _____	

HEREBY THE STUDENT IS CERTIFIED AS :

☐ **SUITABLE**

☐ **UNSUITABLE**

FOR STUDIES / COURSE IN MALAYSIA

COMMENTS :

_____

_____

Date : _____

Signature of Doctor :_____

Name of Doctor :_____

Registration Number :_____

Official Stamp :