GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT

1. PLEASE READ THE 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 AND B) TO BE FILLED BY THE CANDIDATES
   - SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS.
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 3 MONTHS PRIOR TO REGISTRATION
8. UNIVERSITY ONLY ACCEPT MEDICAL EXAMINATION DONE WITHIN 3 MONTH BEFORE REGISTERATION.
9. UNIVERSITY CONCERNED HAS THE RIGHT TO REPEAT THE MEDICAL CHECK-UP SHOULD THERE BE ANY DOUBT OF THE MEDICAL REPORT. ALL COSTS INVOLVED WILL BE PAID BY THE CANDIDATES.

UNIVERSITI PENDIDIKAN SULTAN IDRIS

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

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. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

_____ _____

_____ _____

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

I hereby certify that the information given above is true. I 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) _____	COLOUR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	**YES**	**NO**	**COMMENT**
a. DEFORMITIES			
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**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION	
CHEST X-RAY 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 University/College Official :