HEALTH EXAMINATION GUIDELINES

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. ALL APPLICANTS SHALL UNDERGO HEALTH EXAMINATION WITHIN SEVEN (7) WORKING DAYS UPON ARRIVAL TO MALAYSIA AND **MUST BE DONE** AT **UPM UNIVERSITY HEALTH CENTRE.**
3. FAILURE IN COMPLYING WITH THE ABOVE MATTER WILL RESULT IN REJECTION OF APPLICATION FOR STUDENT PASS.
4. IF THE APPLICANT FAILED THE HEALTH EXAMINATION,STUDENT PASS ENDORSEMENT WILL NOT BE PROCESSED AND THE APPLICANT IS REQUIRED TO LEAVE MALAYSIA.
5. UNIVERSITI PUTRA MALAYSIA RESERVES THE RIGHT TO **REJECT** ANY APPLICATION:
   a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION ; AND/OR
   b) SHOULD THERE BE ANY EVIDENCE THAT APPLICANT HAS GIVEN **FALSE INFORMATION** PERTAINING TO THE RESULTS OF THE HEALTH EXAMINATION.
6. PLEASE FILL IN THE FORM IN **ENGLISH.**
7. PLEASE WRITE IN **CAPITAL LETTERS**.
8. 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
9. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
10. PROSPECTIVE CANDIDATES ARE **STRONGLY ADVISED** TO UNDERGO VACCINATION FOR **HEPATITIS B** BEFORE JOINING UNIVERSITI PUTRA MALAYSIA.
11. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS AND THE RESULTS MUST BE REPORTED IN **ENGLISH.**
12. THE UNIVERSITY RESERVES THE RIGHT TO **REPEAT** FULL MEDICAL CHECK – UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE **ANY DOUBT** IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.

Terms and regulation of Health-related disorder for Admission of International Students to Universiti Putra Malaysia.

1. Communicable Disease

Type of disease/disorder	Example	Registration/admission
• **Contagious** • **Recovery 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 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 Ministry of Health	• Japanese Encephalitis • SARS • Avian flu • Ebola • H1N1	• Registration/admission is prohibited

2. Non - Communicable Disease

Type of disease/disorder	Example	Registration/admission
• Mental Illness An attack that may harm the student or other	• Epilepsy • Schizophrenia • Depression • Bipolar Disorder	A **report is required** from the treating psychiatrist. 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 • Cancer	• Registration/admission is **prohibited**
• Addiction that is direct violation of the Malaysian laws	Drugs such as • Morphine • Canabis • Ampethamine • Metampethamine	• Registration/admission is **prohibited**
• Requires continuous medication • No serious symptoms • Treatment not affecting study	• Hypertension • Diabetes Mellitus • Dyslipidaemia	• May register if treatment does not affect study

UNIVERSITI PUTRA MALAYSIA
BERILMU BERBAKTI

KEMENTERIAN PENDIDIKAN MALAYSIA

HEALTH EXAMINATION REPORT

Passport size photo

COMPULSORY

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
/

COURSE CODE

SEMESTER

FACULTY

MATRIC NO.

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

RELATIONSHIP

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. **AGENTS ARE STRICTLY NOT ALLOWED TO FILL IN THE BOX**.

* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		*IMMEDIATE FAMILY		If "Yes" please state. You are required to submit your medical history/report from your treating physician if you have sought consultation for any of the listed diseases/conditions
	Yes	No	Yes	No	
1. AIDS, HIV					
2. Hepatitis B/C					
3. Tuberculosis					
4. Drug addiction					
5. Congenital or inherited disorder					
6. Allergy/Drugs allergy					
7. Mental illness (depression,ocd,schizo,etc)					
8. Fits, stroke, other neurological disease					
9. Diabetes Mellitus					
10. Hypertension					
11. Heart or vascular disease					
12. Asthma					
13. Thyroid disease					
14. Kidney disease					
15. Cancer					
16. History of surgery					
17. Other illnesses/handicapped					

Current medication (Long term):

_____ _____

_____ _____

IMMUNIZATION HISTORY	DATE IMMUNIZED				
1. Yellow fever					
2. BCG					
3. Typhoid					
4. Meningitis (Quadrivalent)					
5. Hepatitis B					
6. 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**.**

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 conditions 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.

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 BLIND 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		
g. METHAMPHETAMINES		

BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS B ANTIGEN		
b. HEPATITIS B ANTIBODY		
c. HEPATITIS C		
d. HIV		
e. VDRL / TPHA		
f. 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

☐ FOUND TO HAVE (Please State)

_____

_____

☐ HAS MEDICAL PROBLEM (Please State)

_____

_____

_____

☐ IS UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date _____

Signature of Doctor : _____
Name of Doctor : _____
Qualification and : _____
Official stamp of Clinic

Remarks By University Official :

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

☐ FOUND TO HAVE (Please State)

_____

_____

☐ HAS MEDICAL PROBLEM (Please State)

_____

_____

_____

☐ IS UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date _____

Signature of Doctor : _____
Name of Doctor : _____
Qualification and : _____
Official stamp of Clinic

Remarks By University Official :