HEALTH EXAMINATION GUIDELINES

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. PROSPECTIVE CANDIDATES ARE **STRONGLY ADVISED** TO UNDERGO VACCINATION FOR **HEPATITIS B** BEFORE JOINING UNIVERSITI PUTRA MALAYSIA.

7. PLEASE TAKE NOTE THAT IT IS **COMPULSORY** FOR ALL INTERNATIONAL STUDENTS TO DO THEIR MEDICAL CHECK UP FOR UPM STUDENT PASS AT **UPM UNIVERSITY HEALTH CENTRE / PUSAT KESIHATAN UNIVERSITI UPM.**

8. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO **REJECT** ANY APPLICATION:
   (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
   (b) SHOULD THERE BE ANY 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 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	• 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 • Cancer	• Registration/admission is prohibited
• Addiction that is direct violation of the Malaysian 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 PUTRA MALAYSIA
HEALTH EXAMINATION REPORT

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
/

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.
* 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. *Tuberculosis					
4. *Drug addiction					
5. Congenital or inherited disorder					
6. Allergy					
7. Mental illness					
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					

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.

Those who have the listed medical problems above(in 1,2,3 or 4),please kindly DO NOT proceed with your application.

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			
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

(must be written in English Language)

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES		
g. METHAMPHETAMINES		

(must be written in English Language)

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		

(must be written in English Language)

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 :