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 UNIVERSITY PUTRA MALAYSIA.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS AND THE RESULTS MUST BE REPORTED IN **ENGLISH.**
8. THE UNVERSITY / COLLEGE **ONLY ACCEPTS** MEDICAL EXAMINATION DONE WITHIN **60 DAYS** BEFORE REGISTRATION OR WITHIN **30 DAYS** AFTER REGISTRATION.
9. 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
10. THE UNIVERSITY / COLLEGE 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.
11. 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.
12. IT IS STRONGLY RECOMMENDED THAT THIS HEALTH EXAMINATION BE **PERFORMED IN MALAYSIA** BY MALAYSIAN MEDICAL PRACTITIONERS TO ENSURE **COMPLIANCE** WITH THE **MALAYSIAN MINISTRY OF HEALTH GUIDELINES.**

HEALTH CONDITIONS FOR ENTRY OF INTERNATIONAL STUDENTS INTO UPM

(As Per Health Examination Guidelines For Entry Into Malaysian Higher Educational Institutions Issued By The Malaysian Ministry Of Higher Education)

A. TRANSMITTABLE ILLNESSES

NO	TYPES OF ILLNESSES/COMPLICATIONS	EXAMPLES	ACTION TAKEN BASED ON TIME OF DETECTION	
			COMMENCEMENT OF COURSE OF STUDY	DURING COURSE OF STUDY
1	• Transmittable • Difficult to cure on a long-term basis • High treatment cost	• HIV / AIDS • Hepatitis B • Hepatitis C	• Student registration will not be accepted	Allowed to proceed with studies but with the following terms and conditions: • Student will finance their own treatment cost • Permission is granted to pursue the current course only • Allowed to defer studies up to 2 semesters only (if necessary)
2	• Transmittable • Treatable with a specific course of treatment	• Tuberculosis	• Defer registration until completion of treatment (up to 2 semester) • Need confirmation by the attending doctor	• Allowed to continue with course of study • Allowed to defer course of study (if necessary) up to 2 semesters only
3	• Transmittable • Treatable with a short course of treatment	• Malaria • Typhoid • Syphilis (VDRL)	• Can be accepted to register • Required to undergo treatment • Financed by health scheme	• Allowed to continue with course of study • Allowed to go on medical leave (if necessary) up to 2 weeks only • Treatment is financed by health scheme
4	• Transmittable diseases declared as an epidemic by the Malaysian Health Ministry	• Japanese encephalitis • SARS • Avian flu	• Student registration will will not be accepted	• In compliance with the latest health circulars issues by the Malaysian Ministry of Health and WHO

B. CHRONIC NON-TRANSMITTABLE ILLNESSES

NO	TYPES OF ILLNESSES/COMPLICATIONS	EXAMPLES	ACTION TAKEN BASED ON TIME OF DETECTION	
			COMMENCEMENT OF COURSE OF STUDY	DURING COURSE OF STUDY
1	• Illnesses which can pose a risk to self or others • Recurring symptoms which effect studies	• Epilepsy • Schizop • hrenia • Depression	A report is required from the specialist attending. Student can be accepted for registration if: • There are no symptoms for more than 12 months; and • No longer undergoing treatment • Undergoing treatment but student has agreed to self-finance the treatment costs.	Continue with course of study if: • Symptoms do not effect course of study. • Student agrees to self-finance the treatment costs. • Allowed to continue with currentcourse of study only
2	• Symptoms expected to persist for extended periods of time • Obvious and serious symptoms • Lengthy period of treatment	• Dialysis • Cancer	• Student registration will be rejected	Students will be allowed to continue with studies on condition that: • Symptoms do not affect course of study • Students will self-finance the treatment costs
3	• Addictions	• Drugs	• Student registration will be rejected	• Complete course of study
4	• Require ongoing medication regime • No serious symptoms • Treatment does not effect studies	• Hypertension • Diabetis Mellitus • Asthma • Dyslipidemia	Student will be accepted on condition: • Treatment does not interfere with course of study • Student has agreed to self-finance the treatment costs.	Students will be allowed to continue with studies on condition that • Treatment does not interfere with course of study • Student has agreed to self-finance the treatment costs.

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

PROGRAMME

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 Carrier					
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.

---------- ----------

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

☐ 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 :

FOR VISA APPLICATION

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

☐ 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 :