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.
- 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 <u>REPEAT</u> 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.

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
ContagiousRecover is expected to be difficult and delayed	HIV/AIDSHepatitis BHepatitis 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
ContagiousExpected to recover with treatment	MalariaTyphoidSyphilis	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 EncephalitisSARSAvian flu	Registration/admission is prohibited

2. Non - Communicable Disease

Type of diagona/diagraphy	Evample	Dagistration/admission
Type of disease/disorder	Example	Registration/admission
An attack that may harm the	Epilepsy	A report is required from the treating
student or other	Schizophrenia	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	End stage renal failure	Registration/admission is
continue for an unspecified time	requiring dialysis	prohibited
 Apparent and serious symptoms 	Cancer	
Long treatment schedule		
Addiction that is direct violation of	• Drugs	Registration/admission is
the Malaysian laws	Morphine	prohibited
	Canabis	
	Ampethamine	
	Metampethamine	
Requires continuous medication	Hypertension	May register if treatment does not
No serious symptoms	Diabetes Mellitus	affect study
Treatment not affecting study		





UNIVERSITI PUTRA MALAYSIA HEALTH EXAMINATION REPORT

PLEASE USE CAPITAL LETTERS SECTION 1 (To be completed by candidate) (PART A)								Passport size photo																			
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SECTION 1

(PART B) – Please tick ($\sqrt{\ }$) 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, n MEDICAL PROBLEMS	SE		*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					
3. 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)			_	D4==	
IMMUNIZATION HISTORY			T	DATE	IMMUNIZED
Yellow fever BCG					
3. Typhoid					
4. Meningitis (Quadrivalent)					
5. Hepatitis B					
6. Others					
I hereby certify that the information given if there is any false information given		ove is tr	rue. I und	erstand tl	hat my application will be rejected
Date					Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT			
HEIGHT :m	1	BLOOD PRESSURE : _	mmHg
WEIGHT:kg	9	PULSE RATE :_	/ min
VISION TEST : Unaided : (R)	(L)	COLOUR BLIND TEST:	
Aided : (R)	(L)	NORMAL /	ABNORMAL

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

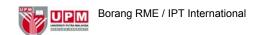
3. SYSTEMIC EXAMINATION								
ITEM	NORMAL	ABNORMAL	COMMENT					
a. EYES (including funduscopy)								
b. EARS								
c. NOSE								
d. ORAL CAVITY / THROAT								
e. NECK								
f. HEART								
g. LUNGS								
h. ABDOMEN / HERNIA ORIFICES								
i. NERVOUS SYSTEM								
j. MENTAL CONDITION								
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								

BI	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								

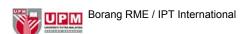
CHEST X-RAY INFORMATION						
CHEST X-RAY NO.						
DATE TAKEN						
PLACE TAKEN						
REPORT						



SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick ($\sqrt{\ }$) in the appropriate box

I certify the	nat I have on this date	examined	
Mr / Ms _		Passport No	·
and foun	d him / her :-		
	IN GOOD HEALTH		
	FOUND TO HAVE (Please Sta	to)	
	FOUND TO HAVE (Flease Sta	ie)	
	HAS MEDICAL PROBLEM (Ple	ease State)	
	IS UNDERGOING TREATMEN	IT FOR: (Please State)	
		(
Date		Signature of Doctor	:
		Name of Doctor Qualification and	:
		Official stamp of Clinic	·
	D 11: " 06: 1		
Remarks	By University Official:		



SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick ($\sqrt{\ }$) in the appropriate box

	at I have on this date		
and found	I him / her :-		
	IN GOOD HEALTH		
	FOUND TO HAVE (Please State	e)	
	HAS MEDICAL PROBLEM (Plea	ase State)	
	IS UNDERGOING TREATMENT	FOR: (Please State)	
Date		Signature of Doctor Name of Doctor Qualification and Official stamp of Clinic	: : :
Remarks	By University Official:		