PUSAT KESIHATAN UNIVERSITI
Universiti Malaysia Perlis, Kampus Pauh Putra, 02600 Arau, Perlis, Malaysia.
Tel : +604 9885068 Fax : +604 9885389

HEALTH EXAMINATION GUIDELINES FOR STUDENT PASS / DEPENDENT PASS ISSUANCE IN MALAYSIA
(Required by the Government of Malaysia)

1. PLEASE READ THE INSTRUCTION CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN THE **ENGLISH** LANGUAGE.
3. PLEASE WRITE IN **CAPITAL LETTERS**.
4. THIS FORM HAS 6 SECTIONS :
   (a) **SECTION 1, 2 AND 3 (PART A AND B) IS TO BE COMPLETED BY THE APPLICANT. ALL FIELDS ARE MANDATORY**; AND
   (b) SECTION 1, 2,3 (PART C), 4,5 AND 6 IS TO BE COMPLETED BY THE EXAMINING DOCTOR AT THE CLINIC / HOSPITAL DULY APPROVED BY EMGS / MOHE
5. **PLEASE COMPLETE ALL THE TESTS REQUIRED** IN THIS FORM.
6. **MEDICAL EXAMINATION REPORT COMPLETION AND SUBMISSION REQUIREMENTS :**

   THIS REPORT MUST TO BE COMPLETED WITHIN 7 WORKING DAYS FROM THE DATE OF ENTRY FOR ONWARDS SUBMISSION OF COMPLETE REPORT TO EMGS BY THE CLINIC/HOSPITAL WITHIN 4 DAYS THEREAFTER.

7. PLEASE ENSURE THE CHEST X-RAY FILM IS LABELLED WITH YOUR NAME AND DATE TAKEN. (IN ENGLISH)

8. UniMAP/EMGS RESERVES THE RIGHT TO REQUEST FOR A REPEAT COMPLETE MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TEST SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. **ALL COSTS INVOLVED SHALL BE BORNE BY THE STUDENTS AND THE DEPENDENTS.** IN THE EVENT OF FILLING THE MEDICAL EXAMINATION, NO REFUND IS PAYABLE.

9. THE RESULTS OF THE HEALTH EXAMINATION WILL BE USE BY UniMAP/EMGS AND/OR THE UniMAP/EMGS APPOINTED INSURANCE COMPANIES IN CONCLUDING THE HEALTH INSURANCE COVERAGE WHICH HAS BEEN CONDITIONALLY OFFERED TO STUDENT/DEPENDENT WITH EFFECT FROM THE DATE OF ENTRY, SUBJECT TO REVIEW AND ACCEPTANCE OF THIS HEALTH EXAMINATION REPORT.

10. UniMAP/EMGS AND/OR THE UniMAP/EMGS APPOINTED INSURANCE COMPANIES RESERVE THE RIGHT TO REVOKE THE HEALTH INSURANCE CONDITIONALLY OFFERED TO STUDENT OR DEPENDENT IF THERE IS EVIDENCE THAT THE STUDENT/DEPENDENT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

    THIS MAY ALSO TRIGGER THE REVOCATION OF STUDENT/DEPENDENT PASS/VISA ISSUED BY THE IMMIGRATION OF MALAYSIA.

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SECTION 1

FOREIGN STUDENT / DEPENDENT CONSENT, AUTHORISATION AND DECLARATION FORM

This is to confirm that I, _____

(Name of Foreign Student / Dependent as in passport)

Passport Number _____ Matric Number _____

hereby irrevocably consent and authorize Dr. _____

(Doctor's Name)

of Pusat Kesihatan Universiti, Universiti Malaysia Perlis to :
(Name of clinic)

i. Carry out a medical examination on me including the testing of blood and urine and the taking of chest x-ray in compliance with the Education Malaysia Global Services' ("EMGS") medical screening requirements ; and

ii. Disclose my health report / records and any other health information to EMGS, the Ministry of High Education, the Ministry of Health, the Immigration Department of Malaysia and any other relevant authorities, as and when it is required to do so.

I also hereby confirm the following :

i. I have not taken / taken * (if taken, please specify) any medication / drugs within the last two (2) weeks; and

(a)_____(b)_____ (c)_____

ii. My last menstrual period was on _____ /_____ /_____ (DD/MM/YY) (FEMALES ONLY)

_____ _____
Signature or thumbprint of Foreign Student / Dependent Date

Witness by :

_____ _____
Signature of Examining Doctor **Name of Examining Doctor**

_____
Clinic's Stamp

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SECTION 2

Reference No :

LETTER OF UNDERTAKING

To : Universiti Malaysia Perlis

Date : _____

Student Name / Dependent Name : _____

Passport Number : _____ Country of Origin : _____

Matric Number : _____

Correspondence Address : _____

_____

Telephone Number : (H) : _____

(H/P) : _____

I declare that in the event I should be diagnosed with any condition that does not require my removal from the country 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.

I confirm that EMGS shall not be responsible in any manner or whatsoever, arising out of EMGS certification of my medical status as suitable to study or reside in Malaysia despite the medical condition described above. I further undertake the hold EMGS harmless from any loss or liability arising from this decision and agree to indemnify and keep EMGS from any loss or liability arising from the decision.

_____ _____
Name of Student (as in passport) Signature of Student

_____
Signature of Dependent

Witness by :

_____ _____
Name of Examining Doctor Signature of Examining Doctor

_____
Clinic's Stamp

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON
IMPORTANT : PLEASE USE CAPITAL LETTERS AND TICK (✓) WHERE APPROPRIATE

Passport size photo (compulsory)

SECTION 3
(To be completed by APPLICANT and all fields are ***MANDATORY)***

(PART A) **DATE OF MEDICAL EXAMINATION** D D M M Y Y

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

NATIONALITY

COUNTRY OF RESIDENCE

DATE OF BIRTH D D M M Y Y

AGE

SEX

MALE	
FEMALE	

MARITAL STATUS

SINGLE	
MARRIED	

BLOOD GROUP

A	B	AB	O

RHESUS

NEGATIVE	POSITIVE

CONTACT NUMBER IN MALAYSIA

ACADEMIC YEAR

MATRIC NUMBER

PROGRAMME OF STUDY

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

DATE OF ARRIVAL IN MALAYSIA D D M M Y Y

The details of blood type recorded here are as reported by the patient and have not been tested or verified to be correct by the medical practitioner completing this online medical screening questionnaire. The medical practitioner completing this from disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering or loss caused by any reliance on this information by any other party.

NAME :_____

PASSPORT NUMBER : _____

SECTION 3

(PART B) – Please tick (✓) in the relevant box.

Declaration of self and family illness. Explain in full if you or your immediate family* has any of the following illnesses.

*Immediate family refer to father, mother, grandparents, brother/sister

MEDICAL HISTORY	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Congenital or Inherited Disorder					
2. Allergy					
3. Mental Illness					
4. Fits, Strokes, other Neurological Disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or Vascular Disease					
8. Asthma					
9. Thyroid Disease					
10. Kidney Disease					
11. Cancer					
12. History of Surgery					
13. Tuberculosis (TB)					
14. Drug Addiction					
15. HIV / AIDS					
16. Hepatitis B					
17. Hepatitis C					
18. Sexually Transmitted Diseases					
19. Color Blindness					
20. Other Illnesses					

If on any medication, please state below :

_____

VACCINAION HISTORY (where applicable)		Yes	No	Date of Vaccination
1.	Yellow Fever			
2.	BCG			
3.	Meningitis (Quadrivalent)			
4.	Hepatitis B			
5.	Polio			
6.	Measles			
7.	Rubella			
8.	Other (specify)			

Notes:

1. *A valid yellow fever vaccination certificated is required from all travelers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.*
2. *All students are required to take vaccines as listed in number 2-7 above.*
3. *The student are required to bring along the International Certificated of Vaccination or Prophylaxis with them for verification of information*

I hereby certify that the given above is true. I understand that my application will be rejected if there is any false information given.

Name of Student / Dependent as in passport : _____

Signature : _____ Date : _____

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 3 – PHYSICAL EXAMINATION
(PART C)
(To be completed by EXAMINING DOCTOR)

* Has the Consent Letter been signed by the foreign student/dependent ? YES / NO * delete as appropriate

* Has the Letter of Undertaking been signed by the foreign student/dependent ? YES / NO * delete as appropriate

1. GENERAL EXAMINATION		
HEIGHT : m WEIGHT : kg BMI :	**BLOOD PRESSURE** SYSTOLIC : mmHg DIASTOLIC : mmHg	**PULSE RATE** : per minute

VISION TEST :

		Normal	Defective
Unaided	Left		
	Right		
Aided	Left		
	Right		

COLOUR VISION TEST :

NORMAL / ABNORMAL

COMMENT :

HEARING ABILITY :

	Normal	Defective	COMMENT
Left			
Right			

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

3. SYSTEMIC EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including fundoscopy)			
b. EARS / HEARING ABILITY			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL STATUS			
k. MUSCULARSKELETAL SYSTEM			
l. LYMPH NODE ENLARGEMENT			
m. GENITOURINARY SYSTEM			

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 4 – LABORATORY RESULT
(To be completed by EXAMINING DOCTOR)

NAME OF LABORATORY

_____

URINE TEST				
ITEM		**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a.	ALBUMIN			
b.	SUGAR			
c.	MICROSCOPY			
d.	OPIATES SENSITIVITIES			
e.	CANNABINOIDS			
f.	AMPHETAMINE-TYPE STIMULANT			

BLOOD TEST				
ITEM		**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a.	HEPATITIS B SURFACE ANTIGEN			
b.	HEPATITIS C ANTIBODY			
c.	HIV			
d.	VDRL / *TPHA			
e.	MALARIA PARASITE			

*TPHA is done if VDRL is reactive
**All test result / report is valid for 6 months

DATE OF LAB TEST

D	D	M	M	Y	Y

_____
Signature of Lab Technologist

_____ _____
Name of Lab Technologist Official Stamp

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 5 – CHEST X-RAY FINDING

NAME OF X-RAY DEPARTMENT

_____

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
Comments (if any)	

_____
Signature of Radiographer

_____
Name of Radiographer

DESCRIPTION	**NORMAL**	**ABNORMAL**
1. Thoracic cage		
2. Heart shape and size (CTR if applicable)		
3. Lung fields		
4. Mediastinum and hila		
5. Pleura/Hemidiaphragms/Costophrenic Angles		
6. Focal Lesion (e.g old/new PTB, malignancy)		
7. Any other abnormalities		
8. Impression		
9. Comment		

_____
Signature of Medical Officer

_____ _____
Name of Medical Officer Official Stamp

NAME :_____

PASSPORT NUMBER : _____

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 6 – CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (✓) in the appropriate box

I certify that I have on this date _____ examined Mr/Ms _____

Passport No. : _____ Matric No. : _____ and in my opinion, the applicant:

ITEM	NORMAL	ABNORMAL
PHYSICAL EXAMINATION		
HIV		
HEPATITIS B		
HEPATITIS C		
MALARIA		
SEXUALLY TRANSMITTED DISEASES		
URINE FOR AMPHETAMINE TYPE STIMULANTS (ATS)(SCREENING TEST)		
URINE FOR OPIATES (SCREENING TEST)		
URINE FOR CANNABINOIDS (SCREENING TEST)		
TUBERCULOSIS		
OTHER (PLEASE SPECIFY UNDER COMMENTS)		

☐ IS IN GOOD HEALTH AND SUITABLE TO STUDY OR TO RESIDE IN MALAYSIA

☐ IS NOT IN GOOD HEALTH BUT CAN BE CERTIFIED SUITABLE TO STUDY OR TO RESIDE IN MALAYSIA as he/she has given the undertaking to undergo the relevant medical treatment at his/her own cost for (Please state)

_____

☐ IS UNSUITABLE TO STUDY AND / OR TO RESIDE IN MALAYSIA

Comment : _____

_____

Signature of Medical Officer : _____

Date : ☐☐☐☐☐☐ (D D M M Y Y)

Name and Official Stamp of Medical Officer : _____

Note: In completing this form, particular attention should be paid to the following points:

i. The conclusion shall only be drawn after taking into consideration the guidelines issued by MOHE/MOH as communicated by EMGS.