



**HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO  
UNIVERSITY MALAYSIA PAHANG AL-SULTAN ABDULLAH  
INTERNATIONAL STUDENT  
POST ARRIVAL MEDICAL CHECK UP**

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 **4 SECTIONS**:
  - (A) SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATES; AND
  - (B) SECTION 2,3, 4 & 5 TO BE FILLED BY THE EXAMINING DOCTOR
5. THE UNIVERSITY ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN 90 DAYS POST ARRIVAL IN MALAYSIA OR WITHIN 30 DAYS AFTER REGISTRATION AND MUST BE DONE AT ANY CLINIC AND HOSPITAL IN MALAYSIA.
6. PLEASE ATTACH ALL THE ORIGINAL TESTS AND DOCUMENTS REQUIRED IN THIS FORM.
7. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION;
  - (A) BASED ON THE RESULTS OF THE HEALTH EXAMINATION (PLEASE REFER NEXT PAGE FOR FURTHER INFORMATION); OR
  - (B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

**CHECKLIST MEDICAL CHECKUP**

<b>PAGE</b>	<b>CHECKLIST</b>	<b>COMPLETE</b>	<b>INCOMPLETE</b>
<b>SECTION 1 PART (A)</b>	<b>PERSONAL INFORMATION</b>		
<b>SECTION 1 PART (B)</b>	<b>DECLARATION SELF AND FAMILY ILLNESS</b>		
<b>SECTION 2 (1, 2 &amp; 3)</b>	<b>VITAL SIGN AND PHYSICAL EXAMINATION</b>		
<b>SECTION 2 (4)</b>	<b>MENTAL HEALTH ASSESMENT</b>		
<b>SECTION 3</b>	<b>URINE &amp; BLOOD TEST</b>		
<b>SECTION 4</b>	<b>CHEST X RAY INFORMATION</b>		
<b>SECTION 5</b>	<b>CERTIFICATION BY EXAMINING DOCTOR</b>		
	<b>CERTIFICATION BY EXAMINING UMP DOCTOR</b>		

**\*PLEASE TICK ✓ IN THE BOX COMPLETE / INCOMPLETE**

## SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMAIL ADDRESS

NATIONALITY

CONTACT NUMBER IN MALAYSIA

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

INSTITUTE IN MALAYSIA

ACADEMIC YEAR

COURSE OF STUDY

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

The medical practitioner completing this form 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.

**SECTION 1 (PART B)**

Declaration of self and family illness. Explain in full if you or your immediate\* family has any of the following illnesses. \* Immediate family refers to mother, brothers / sisters.

ITEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Tuberculosis					
2. Hepatitis B					
3. Hepatitis C					
4. HIV					
5. Drugs use/abuse					
a. Opiates					
b. Methamphetamine					
c. Amphetamine					
d. Cannabinoids					
6. Congenital or Inherited Disorder					
7. Allergy					
8. Mental Illness					
9. Epilepsy					
10. Stroke / Neurological Disease					
11. Diabetes Mellitus					
12. Hypertension					
13. Heart or Vascular Disease					
14. Asthma					
15. Thyroid Disease					
16. Kidney Disease					
17. Cancer					
18. History of Surgery					
19. Sexually Transmitted Diseases					
20. History of Blood Transfusion					
21. Other Illness:					

Current medication (Long Term)

VACCINATION 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. Others: (specify)			

Notes:

- \* A valid Yellow Fever vaccination certificate is required from all travellers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
- All students are required to take vaccines as listed in numbers 2-7 above.
- The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information

## SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

FULL NAME (AS IN PASSPORT)

PASSPORT NUMBER

TYPE OF

APPLICATION



DATE OF MEDICAL SCREENING

### 1. BASIC MEASUREMENT

HEIGHT (m) :	WEIGHT (kg)	BMI(kg/m <sup>2</sup> )	PULSE RATE (PER MINUTE)	BLOOD PRESSURE:	
				SYSTOLIC (mmHg)	DIASTOLIC (mmHg)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>VISION TEST</b>	<b>NORMAL</b>	<b>DEFECTIVE</b>			
UNAIDED (L)	<input type="text"/>	<input type="text"/>	<b>COLOR VISION TEST</b>	<input type="text"/>	
UNAIDED (R)	<input type="text"/>	<input type="text"/>	<b>COMMENT</b>	<input type="text"/>	
AIDED (L)	<input type="text"/>	<input type="text"/>			
AIDED (R)	<input type="text"/>	<input type="text"/>			
<b>HEARING ABILITY</b>	<b>NORMAL</b>	<b>DEFECTIVE</b>	<b>COMMENT</b>		
LEFT	<input type="text"/>	<input type="text"/>	<input type="text"/>		
RIGHT	<input type="text"/>	<input type="text"/>	<input type="text"/>		

### 2. GENERAL EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

### 3. SYSTEMIC EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
g. EYES (including funduscopy)			
h. EARS			
i. NOSE			
j. ORAL CAVITY / THROAT			
k. NECK			
l. CARDIOVASCULAR SYSTEM			
m. RESPIRATORY SYSTEM			
n. ABDOMEN/HERNIAL ORIFICES			
o. NERVOUS SYSTEM			
p. MUSCULOSKELETAL SYSTEM			

## SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

### 4. MENTAL HEALTH ASSESSMENT

#### MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

<b>A.</b>	<b>General Appearance</b>	<b>Untidy</b>	<b>Neat &amp; Tidy</b>
<b>B.</b>	<b>Speech Quality</b>	<b>No/Abnormal</b>	<b>Yes/Normal</b>
	Coherent		
	Relevant		
<b>C.</b>	<b>Mood</b>	<b>Yes/Abnormal</b>	<b>No/Normal</b>
	Depressed*		
	Anxious		
	Irritable		
<b>D.</b>	<b>Affect</b>	<b>Inappropriate</b>	<b>Appropriate</b>
<b>E.</b>	<b>Thought</b>	<b>Yes/Abnormal</b>	<b>No/Normal</b>
	Delusion		
	Suicidity*		
<b>F.</b>	<b>Perception</b>	<b>Yes/Abnormal</b>	<b>No/Normal</b>
	Hallucination		
<b>G.</b>	<b>Orientation</b>	<b>No/Abnormal</b>	<b>Yes/Normal</b>
	Time		
	Place		
	Person		

\*Note: Refer to Questionnaire. If 'Abnormal' for any of item C, E, F or G, to certify as UNSUITABLE.

#### QUESTIONNAIRE

<b>PART A: MOOD</b>		<b>Yes/Abnormal</b>	<b>No/Normal</b>
A.	During the past month, have you been feeling down/depressed for most of the days?		
B.	During the past month, have you lost interest in doing things that you like for most of the days?		

If 'Yes' to question A or B, to tick 'Abnormal' at DEPRESSED in assessment box.

<b>PART B: SUICIDALITY</b>		<b>Yes/Abnormal</b>	<b>No/Normal</b>
C.	Do you feel that life is not worth living?		
D.	Do you have any thoughts about ending your life?		

If 'Yes' to question C or D, to tick 'Abnormal' at SUICIDALITY in assessment

### SECTION 3 - INVESTIGATIONS

URINE TEST			
ITEM	POSITIVE	NEGATIVE	COMMENT
a. ALBUMIN			
b. SUGAR			
d. OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN)			
e. CANNABINOIDS			
f. AMPHETAMINE TYPE STIMULANT			

BLOOD TEST			
ITEM	POSITIVE / ABNORMAL	NEGATIVE / NORMAL	COMMENT
a. HEPATITIS Bs ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
d. MALARIAL PARASITES			
e. VDRL			
f. TPHA*			
g. RBS / FBS			

\* TPHA is done if VDRL is reactive

## SECTION 4 - CHEST X-RAY INFORMATION

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

DATE TAKEN

PLACE TAKEN

CHEST X-RAY NUMBER

ITEM	NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
a. THORACIC CAGE			
b. HEART SHAPE AND SIZE (CTR > 0.55 AND IN FAILURE OR SIGNIFICANT CARDIOMEGALY)			
c. LUNG FIELDS			
d. MEDIASTHNUM AND HILAR REGION			
e. PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES			
f. FOCAL LESION			
g. ANY OTHER ABNORMALITIES			
h. IMPRESSION			

## SECTION 5 – CERTIFICATION BY EXAMINING DOCTOR

Please tick (/) the appropriate box

I certify that I have on this date \_\_\_\_\_ examined

Mr. / Ms. \_\_\_\_\_

Passport Number \_\_\_\_\_ and found him/her with the following disease/condition:

ITEM	ABNORMAL
1. Tuberculosis	
2. Hepatitis B	
3. Hepatitis C	
4. HIV	
5. Cancer	
6. Epilepsy	
7. Psychiatric Illness	
8. Drugs	
a. Opiates	
b. Amphetamine/Methamphetamine	
c. Cannabinoids	
9. Malaria	
10. Sexually Transmitted Disease	
11. Others (Please Specify)	

HEREBY THE STUDENT IS CERTIFIED AS:

SUITABLE       UNSUITABLE

FOR STUDIES/COURSE IN MALAYSIA.

COMMENTS:

DATE : \_\_\_\_\_

SIGNATURE OF DOCTOR : \_\_\_\_\_

NAME OF DOCTOR : \_\_\_\_\_

QUALIFICATION : \_\_\_\_\_

HOSPITAL/CLINIC : \_\_\_\_\_

REGISTRATION NUMBER : \_\_\_\_\_

OFFICIAL STAMP : \_\_\_\_\_



اونيورسيتي مليسيا فهغ السلطان عبدالله  
UNIVERSITI MALAYSIA PAHANG  
AL-SULTAN ABDULLAH

**CERTIFICATION BY THE EXAMINING DOCTOR (UMP OFFICIAL)**

Name of Doctor: .....

Qualification: .....

Hospital/ Clinic: .....

Registration Number: .....

To whom it may concern,

I hereby certify that Mr/ Mrs/ Miss ..... bearing  
passport no. .... is deemed medically **fit/ not fit** to study in Malaysia, in  
line with the mandatory guidelines by the Ministry of Education (MOE), Malaysia.

.....

Signature of the Doctor:

Official Stamp