HEALTH EXAMINATION GUIDELINE FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1 ALL APPLICANTS **SHALL** UNDERGO HEALTH EXAMINATION WITHIN SEVEN (7) WORKING DAYS UPON ARRIVAL IN MALAYSIA.

2 FAILURE IN COMPLYING WITH THE ABOVE MATTER WILL RESULT IN REJECTION OF APPLICATION FOR STUDENT PASS.

3 APPLICANTS ARE REQUIRED TO UNDERGO HEALTH EXAMINATION AT CERTIFIED EDUCATION MALAYSIA GLOBAL SERVICES (EMGS) PANEL CLINICS / HEALTH CENTRE OF PUBLIC UNIVERSITIES.

4 PLEASE FILL IN THE FORM IN **ENGLISH**.

5 IF THE APPLICANT FAILED THE HEALTH EXAMINATION, STUDENT PASS ENDORSEMENT WILL NOT BE PROCESSED AND THE APPLICANT IS REQUIRED TO LEAVE MALAYSIA.

6 APPLICANTS WHO FAILED THEIR HEALTH EXAMINATION **MAY** SUBMIT THEIR APPEAL APPLICATION WITHIN THREE (3) WORKING DAYS AFTER RECEIVING HEALTH EXAMINATION RESULT. ANY APPLICATION SUBMITTED AFTER THE STIPULATED PERIOD WILL NOT BE PROCESSED.

7 THE GOVERNMENT OF MALAYSIA RESERVES THE RIGHT TO REJECT ANY APPLICATION:

a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; AND/OR
b) SHOULD THERE BE ANY EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION PERTAINING TO THE RESULTS OF THE HEALTH EXAMINATION.

SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

NATIONALITY

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

EMAIL ADDRESS

CONTACT NUMBER IN MALAYSIA

INSTITUTION 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
	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 Illnesses: __________________ __________________					

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:

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

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.

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(Signature of Applying Candidate)

Date:

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

1. BASIC MEASUREMENT

HEIGHT (m) :	WEIGHT (kg)	BMI(kg/m²)	PULSE RATE (PER MINUTE)	BLOOD PRESSURE: SYSTOLIC (mmHg)	DIASTOLIC (mmHg)

VISION TEST	NORMAL	DEFECTIVE
UNAIDED (L)		
UNAIDED (R)		
AIDED (L)		
AIDED (R)		

COLOUR VISION TEST

COMMENT

HEARING ABILITY	NORMAL	DEFECTIVE	COMMENT
LEFT			
RIGHT			

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			

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	General appearance		Neat & tidy	☐	Untidy	☐
B.	Speech Quality	Coherent	Yes	☐	No	☐
		Relevant	Yes	☐	No	☐
C.	Mood	Depressed*	Yes	☐	No	☐
		Anxious	Yes	☐	No	☐
		Irritable	Yes	☐	No	☐
D.	Affect		Appropriate	☐	Inappropriate	☐
E.	Thought					
	Delusion		Yes	☐	No	☐
	Suicidality*		Yes	☐	No	☐
F.	Perception					
	Hallucination		Yes	☐	No	☐
G.	Orientation					
	Time		Yes	☐	No	☐
	Place		Yes	☐	No	☐
	Person		Yes	☐	No	☐

***Note: Refer to Questionnaire**

If 'Yes' for any of item C, E, F or G, to certify as UNSUITABLE.

QUESTIONNAIRE

PART A: MOOD					
A.	During the past month, have you been feeling down/ depressed for most of the days?	Yes	☐	No	☐
B.	During the past month, have you lost interest in doing things that you like for most of the days?	Yes	☐	No	☐
If 'Yes' to question 1 or 2, to tick 'Yes' at DEPRESSED in assessment box.					
PART B: SUICIDALITY					
C.	Do you feel that life is not worth living?	Yes	☐	No	☐
D.	Do you have any thoughts about ending your life?	Yes	☐	No	☐
If 'Yes' to question 3 or 4, to tick 'Yes' at SUICIDALITY in assessment box.					

SECTION 3 - INVESTIGATIONS

URINE TEST

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

BLOOD TEST

ITEM	POSITIVE / ABNORMAL	NEGATIVE / NORMAL	COMMENT
a. HEPATITIS B's ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
d. MALARIA PARASITES			
e. VDRL & TPHA*			

*TPHA is done if VRDL is reactive

X-RAY REPORT

CHEST X RAY INFORMATION

DATE TAKEN

CHEST X-RAY NUMBER

PLACE TAKEN

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. MEDIASTINUM AND HILAR REGION			
e. PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES			
f. FOCAL LESION			
g. ANY OTHER ABNORMALITIES			
h. IMPRESSION			

SECTION 4 – CERTIFICATION BY THE 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:

ITEMS	ABNORMAL
1. Tuberculosis	
2. Hepatitis B	
3. Hepatitis C	
4. HIV	
5. Cancer	
6. Epilepsy	
7. Psychiatric Illness	
8. Drugs a. Opiates b. Methamphetamine c. Amphetamine d. Cannabinoids	
9. 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

HEALTH DECLARATION FORM FOR APPLICANTS

I hereby declare that I am free from the following diseases/conditions:

<table>
<tr><th rowspan="2">ITEMS</th><th colspan="2">SELF</th><th>IF YES, PLEASE STATE</th><th rowspan="17">IF YOU HAVE SOUGHT CONSULTATION FOR ANY OF THE LISTED DISEASES/CONDITIONS, YOU ARE REQUIRED TO SUBMIT YOUR MEDICAL HISTORY/REPORT FROM YOUR TREATING PHYSICIAN TO EDUCATION MALAYSIA GLOBAL SERVICES (EMGS) PANEL CLINIC/UNIVERSITY HEALTH CENTRE.</th></tr>
<tr><th>YES</th><th>NO</th><th></th></tr>
<tr><td>Tuberculosis</td><td></td><td></td><td></td></tr>
<tr><td>Hepatitis B</td><td></td><td></td><td></td></tr>
<tr><td>Hepatitis C</td><td></td><td></td><td></td></tr>
<tr><td>HIV</td><td></td><td></td><td></td></tr>
<tr><td>Drug use/abuse of:</td><td colspan="3"></td></tr>
<tr><td>1. Opiates</td><td></td><td></td><td></td></tr>
<tr><td>2. Cannabinoids</td><td></td><td></td><td></td></tr>
<tr><td>3. Amphetamine</td><td></td><td></td><td></td></tr>
<tr><td>4. Methamphetamine</td><td></td><td></td><td></td></tr>
<tr><td>Sexually Transmitted Diseases</td><td></td><td></td><td></td></tr>
<tr><td>Congenital or Inherited Disorder</td><td></td><td></td><td></td></tr>
<tr><td>Cancer</td><td></td><td></td><td></td></tr>
<tr><td>Epilepsy</td><td></td><td></td><td></td></tr>
<tr><td>Psychiatric Illness</td><td></td><td></td><td></td></tr>
<tr><td>Other illness</td><td></td><td></td><td></td></tr>
</table>

I declare that I will submit myself for compulsory Post-Arrival Health Examination as per Malaysian regulations. In the event that I should be diagnosed with any condition that deems me **UNSUITABLE** for studies, I will bear the cost of leaving Malaysia and will adhere to the immigration requirements on the visit pass and exit before the pass expiration, or any deadline given to me whichever is earlier.

I declare that in the event I should be diagnosed with any conditions that does not require my removal from Malaysia 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 Panel Clinic/University Health Centre shall not be responsible in any manner or whatsoever, arising out of EMGS Panel Clinic/University Health Centre certification of my medical status as suitable to study or reside in Malaysia despite the medical condition described above. I further undertake to hold EMGS Panel Clinic/University Health Centre harmless from any loss or liability arising from this decision and agree to indemnify and keep EMGS Panel Clinic/University Health Centre from any loss or liability arising from this decision.

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Date (Name of applicant)