UNIVERSITI MALAYSIA PAHANG
AL-SULTAN ABDULLAH

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

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

***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:

1. * 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.
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

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/m²)	PULSE RATE (PER MINUTE)	BLOOD PRESSURE: SYSTOLIC (mmHg)	DIASTOLIC (mmHg)

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

COLOR VISION TEST

COMMENT

HEARING ABILITY	NORMAL	DEFECTIVE
LEFT		
RIGHT		

COMMENT

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

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

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

QUESTIONNAIRE

PART A: MOOD			
		Yes/Abnormal	**No/Normal**
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.

PART B: SUICIDALITY			
		Yes/Abnormal	**No/Normal**
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 : _____

UNIVERSITI MALAYSIA PAHANG
AL-SULTAN ABDULLAH

CERTIFICATION BY THE EXAMINING DOCTOR (UMPSA 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 Higher Education (MOHE), Malaysia.

……

Signature of the Doctor:

Official Stamp & Date