

# HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. Please read the instructions carefully before filling in the form.
2. Please fill in the form in English and in CAPITAL letters.

## INSTRUCTIONS TO CLINIC

1. This form has 5 sections:
  - A. Section 1 (PART A) to be filled by the student; and
  - B. Section 1 (PART B), 2, 3, 4 and 5 to be filled by the examining doctor.
2. Please complete all required examination / tests mentioned in this form.

## INSTRUCTIONS TO STUDENT

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. If the applicant fails the health examination, the student pass endorsement will not be processed and the applicant is required to leave Malaysia.
5. Applicants who fail 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.
6. 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.

# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS



## 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.

**EDUCATION MALAYSIA GLOBAL SERVICES (986610-U)**

Education Malaysia One-Stop-Centre, 20th Floor, Menara TA One, 22, Jalan P.Ramlee, 50250 Kuala Lumpur, Malaysia

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# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

## 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.

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# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

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

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

EMGS REFERENCE NUMBER

### 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. PALLOR	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. CYANOSIS	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. JAUNDICE	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. OEDEMA	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. SKIN DISEASES	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 3. SYSTEMIC EXAMINATION

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

## 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>Yes</b>	<b>No</b>
	Coherent		
	Relevant		
<b>C.</b>	<b>Mood</b>	<b>Yes</b>	<b>No</b>
	Depressed		
	Anxious		
	Irritable		
<b>D.</b>	<b>Affect</b>	<b>Appropriate</b>	<b>Inappropriate</b>
<b>E.</b>	<b>Thought</b>	<b>Yes</b>	<b>No</b>
	Delusion		
	Suicidity*		
<b>F.</b>	<b>Perception</b>	<b>Yes</b>	<b>No</b>
	Hallucination		
<b>G.</b>	<b>Orientation</b>	<b>Yes</b>	<b>No</b>
	Time		
	Place		
	Person		

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

### QUESTIONNAIRE

<b>PART A: MOOD</b>		<b>Yes</b>	<b>No</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 'Yes' at DEPRESSED in assessment box.

<b>PART B: SUICIDALITY</b>		<b>Yes</b>	<b>No</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 'Yes' at SUICIDALITY in assessment box.

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## SECTION 3 - INVESTIGATIONS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF LAB TEST

NAME OF LAB

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 Bs ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
d. MALARIAL PARASITES			
e. VDRL			
f. TPHA*			

\* TPHA is done if VDRL is reactive

# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

## SECTION 4 - CHEST X-RAY INFORMATION

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE TAKEN

PLACE TAKEN

CHEST X-RAY NUMBER

COMMENT

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			

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# HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

## SECTION 5 - 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:

TYPE OF APPLICATION

EMGS REFERENCE NUMBER

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:

NAME OF DOCTOR

DATE

QUALIFICATION

HOSPITAL/CLINIC

REGISTRATION NUMBER

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