HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIA HIGHER EDUCATIONAL INSTITUTIONS

1 PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM

2 PLEASE FILL IN THE FORM IN ENGLISH

3 PLEASE WRITE IN CAPITAL LETTERS

4 THIS FORM HAS 4 SECTIONS

A) SECTION 1 (PART A & B) TO BE FILLED IN BY THE APPLICANT
B) SECTION 2, 3 & 4 TO BE FILLED IN BY THE EXAMINING DOCTOR

5 PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM

6 THE UNIVERSITY / COLLEGE ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN 60 DAYS BEFORE REGISTRATION OR WITHIN 30 DAYS AFTER REGISTRATION

7 PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS

8 PLEASE BRING ALONG CHEST X-RAY FILM AND REPORT FOR REGISTRATION

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

10 CHEST XRAY DONE WITHIN 6 MONTHS PRIOR TO REGISTRATION CAN BE ACCEPTED

11 THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO REPEAT FULL MEDICAL CHECKUP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED ALL COST INVOLVED SHALL BE BORNE BY THE CANDIDATES

12 THE UNIVERSITY/COLLEGE RESERVES THE RIGHT TO REJECT ANY APPLICATION.

A) BASED ON THE RESULTS OF THE HEALTH EXAMINATION OR
B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS

TAYLOR'S UNIVERSITY

Wisdom · Integrity · Excellence

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

PLEASE USE CAPITAL LETTERS

Passport size photo

SECTION 1 (To be completed by candidate)

(PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH

D D M M Y Y

AGE

SEX

MALE

FEMALE

MARITAL STATUS

SINGLE

MARRIED

ACADEMIC YEAR

/

COURSE CODE

SEMESTER

FACULTY

MATRIC NO.

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1 (To be completed by candidate)
(PART B) - Please tick (√) in the relevant box.

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

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state.
	Yes	No	Yes	No	
1 Congenital or inherited disorder					
2 Allergy					
3 Mental illness					
4 Fits, stroke, other neurological disease					
5 Diabetes Mellitus					
6 Hypertension					
7 Heart or vascular disease					
8 Asthma					
9 Thyroid disease					
10 Kidney disease					
11 Cancer					
12 Tuberculosis					
13 Drug addiction					
14 AIDS, HIV					
15 History of surgery					
16 Other illnesses					

Current medication (Long term)

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1 Yellow Fever					
2 BCG					
3 Meningitis (Quadrivalent)					
4 Hepatitis B					
5 Others:					

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.

…… ……..

Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE: _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____/min
VISION TEST : Unaided: (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST: NORMAL / ABNORMAL

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

3. SYSTEMIC EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCUSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION	
CHEST X-RAY NO	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date examined
Mr / Ms Passport No
and found him / her :-

☐ IN GOOD HEALTH

☐ HAS MEDICAL PROBLEM (Please State)

_____
_____
_____

☐ IS UNDERGOING TREATMENT FOR : (Please State)

_____
_____
_____

Date _____

Signature of Doctor : _____
Name of Doctor : _____
Qualification and : _____
Official stamp of Clinic

Remarks By University Official :