

**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** 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 APPLICANT; AND
  - b) SECTION 2,3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE THE ENTIRE TEST REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPT MEDICAL EXAMINATION DONE WITHIN **90 DAYS** BEFORE ARRIVAL IN MALAYSIA.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **CHEST X-RAY FILM (OR DIGITAL IMAGES) AND REPORT** FOR REGISTRATION, FOR THE PURPOSE OF VERIFICATION, IF NECESSARY.
9. PLEASE ENSURE THE X-RAY FILMS OR DIGITAL IMAGES ARE **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH).
10. CHEST X-RAY DONE WITHIN **6 MONTHS PRIOR** TO REGISTRATION CAN BE ACCEPTED.
11. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO **REPEAT** FULL MEDICAL CHECK UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED, ALL COSTS 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.

## HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

BLOOD GROUP (RHESUS)

NATIONALITY

CONTACT NUMBER IN MALAYSIA

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

ACADEMIC YEAR

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

The details of the blood type recorded here are as reported by the patient and have not been tested or verified to be correct by the medical practitioner completing this online medical screening questionnaire. 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  
Tel : +603 2782 5888 Fax: +603 2711 8533 Portal: [www.educationmalaysia.gov.my](http://www.educationmalaysia.gov.my)

## 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.

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	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. History of Surgery					
13. Tuberculosis (TB)					
14. HIV / AIDS					
15. Hepatitis B					
16. Sexually Transmitted Diseases					
17. Drug Addiction					
18. 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 :

- \*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

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>	<b>COLOR VISION TEST</b>	<input type="text"/>
UNAIDED (L)	<input type="text"/>	<input type="text"/>	<b>COMMENT</b>	<input type="text"/>
UNAIDED (R)	<input type="text"/>	<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"/>	

### 2. GENERAL EXAMINATION

ITEM	YES / ABNORMAL	NO / NORMAL	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. MENTAL STATUS	<input type="text"/>	<input type="text"/>	<input type="text"/>
q. MUSCULOSKELETAL SYSTEM	<input type="text"/>	<input type="text"/>	<input type="text"/>

## HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

### SECTION 3 - LABORATORY RESULTS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF LAB TEST

NAME OF LAB

#### URINE TEST

ITEM	POSITIVE / ABNORMAL	NEGATIVE / NORMAL	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			
c. VDRL			
d. TPHA			
e. MALARIAL PARASITES			

\* TPHA is done if VDRL is reactive

\*\* all test results / reports is valid for 6 months

## HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

### SECTION 4 - CHEST X-RAY FINDINGS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF CHEST X-RAY

PLACE OF CHEST X-RAY

CHEST X-RAY NO.

COMMENT

ITEM	NORMAL	ABNORMAL	COMMENT
THORACIC CAGE			
HEART SHAPE AND SIZE (CTR IF APPLICABLE)			
LUNG FIELDS			
MEDIASTHNUM AND HILA			
PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES			
FOCAL LESION			
ANY OTHER ABNORMALITIES			
IMPRESSION			

## HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

### SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

TYPE OF APPLICATION

DATE OF CERTIFICATION

ITEM	ABNORMAL
HIV	
HEPATITIS B	
TUBERCULOSIS	
MALARIA	
TYPHOID	
SEXUALLY TRANSMITTED DISEASES	
CANCER	
EPILEPSY	
PSYCHIATRIC ILLNESS	
HIS/HER URINE CONTAINS OPIATES	
HIS/HER URINE CONTAINS CANNABINOIDS	
HIS/HER URINE CONTAINS AMPHETAMINE	
EBOLA	
OTHERS	

HEREBY THE STUDENT IS CERTIFIED AS

SUITABLE  UNSUITABLE

FOR STUDY IN MALAYSIA.

COMMENT

NAME OF EXAMINING DOCTOR

QUALIFICATION OF EXAMINING DOCTOR

HOSPITAL/CLINIC REGISTRATION NUMBER

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

## HEALTH DECLARATION FORM FOR APPLICANTS

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

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

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.

.....  
**Date (dd/mm/yyyy)**

.....  
**Name of applicant as indicated in the passport**

.....  
**Applicant's signature**

.....  
**Applicant's passport number**

**Kindly ensure all information requested in this form is complete and updated in English Language.**