UNIVERSITI MALAYSIA KELANTAN	UMK/A10/05/2022 Pind. 1	Tarikh Kuatkuasa / *Effective Date*: 06/02/2022

HEALTH EXAMINATION REPORT

MALAYSIAN GRADUATE SCHOOL OF ENTREPRENEURSHIP & BUSINESS (MGSEB)

GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT

1. PLEASE READ THIS 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 2 SECTIONS
5. SECTION 1 (PART A & B) TO BE FILLED BY THE CANDIDATES
6. SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR
7. PLEASE COMPLETE ALL THE TEST REQUIRED IN THIS FORM
8. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS AND THE RESULTS MUST BE REPORTED IN ENGLISH. IT MUST BE DONE WITHIN 2 MONTHS PRIOR TO REGISTRATION
9. PLEASE BRING ALONG THE CHEST X-RAY FILM AND REPORT
    a. PLEASE ENSURE THE X-RAY FILM IS LABELLED WITH YOUR NAME AND DATE TAKEN (IN ENGLISH)
    b. CHEST X-RAY MUST BE DONE WITHIN 6 MONTHS PRIOR TO REGISTRATION
10. UNIVERSITY HEALTH CENTRE CONCERNED HAS THE RIGHT TO REPEAT THE
11. MEDICAL CHECK-UP SHOULD THERE BE ANY DOUBT OF THE MEDICAL REPORT. ALL COST INVOLVED WILL BE PAID BY THE CANDIDATES
12. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION:
    a. BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
    b. SHOULD THERE BE ANT EVIDENCE THAT APPLICANT HAS GIVEN FALSE
13. INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

1. Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
Contagious Recover is expected to be difficult and delayed	• HIV/AIDS • Hepatitis B • Hepatitis C	• Registration / admission is prohibited
Contagious Expected to recover with treatment	• Tuberculosis	• Registration / admission is must be deferred until treatment in home country is completed Deferment should not be for more than two semester • Registration requires confirmation from the physician in charge that treatment has been completed
• Contagious • Expected to recover with treatment	• Malaria • Typhoid • Syphilis	Registration / admission is allowed only after treatment is completed in home country
• Contagious disease that are declared as epidemic by the Malaysian Ministy of Health	• Japanese • Encephalitis • SARS • Avian Flu	Registration / admission is prohibited

2. Non — Communicable Disease

Type of disease / Disorder	Example	Registration/Admission
• An attack that may harm the student or other	• Epilepsy • Schizophrenia	• A report is required from the treating specialist. May be accepted for registration / admission if any of the following is met: • Symptom-free for months • Treatment is completed

• Disease or disorder is expected to continue for an unspecified time Apparent and serious symptoms • Long treatment schedule	• End stage renal failure requiring dialysis • Canser	• Registration / admission is prohibited
• Addiction that is direct violation of the Malaysia laws	• Drugs • Morphine • Canabis • Ampethamine • Metampethamine	• Registration / admission is prohibited
• Requires continuous medication • No serious symptoms • Treatment not affecting study	• Hypertension • Diabetes Mellitus	• May register if treatment does not affect study

UNIVERSITI MALAYSIA KELANTAN

HEALTH EXAMINATION REPORT
UNIVERSITI MALAYSIA KELANTAN

Passport size photo

PLEASE USE CAPITAL LETTERS
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

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEST OF KIN'S CONTACT NUMBER

SECTION 1
(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. AIDS,HIV					
2. Hepatitis B/C					
3. Congenital or inherited disorder					
4. Allergy					
5. Mental liness					
6. Fits,stroke,other neurological disease					
7. Diabetes Mellitus					
8. Hypertension					
9. Heart or vascular disease					
10. Asthma					
11. Thyroid disease					
12. Kidney disease					
13. Cancer					
14. Tuberculosis					
15. Drug addiction					
16. History of surgery					
17. Other Illnesses					

Current medication (Long term)

_____ _____

_____ _____

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

I hereby certify that the information given above is true 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 : : (R) _____ (L) _____ Unaided : (R) : (R) _____ (L) _____ Aided	COLOR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	**YES**	**NO**	**COMMENT**
a. DEFORMITES			
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			
NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 – INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
URINE FL-ME		
URINE DRUG * (*completed by UMK Medical Officer) a) Morphine b) Canabis c) Ampethamine d) Metampethamine		

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

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR
Please tick (a) in the appropriate box

I certify that I have on this date _____ examined

Mr/Mrs _____ Passport No. _____

And found him/her:-

☐ IN GOOD HEALTH

☐ HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please state)

_____

_____

_____

☐ UNDERGOING TREATMENT FOR: (Please state)

_____

_____

_____

Date : _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification : _____

Hospital/Clinic : _____

Registration Number

Official Stamp : _____

Remarks By UMK Medical Officer :

Lampiran B

Carta Alir Pemeriksaa Kesihatan Pelajar Antarabangsa di IPT Malaysia