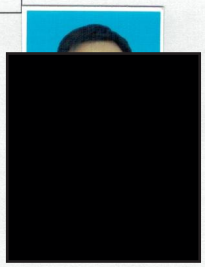
HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. PLEASE READ THE INTRUCTIONS 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 EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVESITY/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 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.

UNIMAS
UNIVERSITI MALAYSIA SARAWAK

KEMENTERIAN PENDIDIKAN TINGGI

UNIVERSITI MALAYSIA SARAWAK



HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate)
(PART A)

FULL NAME (AS IN PASSPORT)
B O [redacted]

INTERNATIONAL PASSPORT NO.
E 9 9 [redacted]

NATIONALITY
C H I N E S E

CONTACT NUMBER
[redacted]

DATE OF BIRTH
1 1 1 2 8 8
D D M M Y Y

AGE
3 2

SEX
MALE ☑
FEMALE ☐

MARITUAL STATUS
SINGLE ☐
MARRIED ☑

ACADEMIC YEAR
P H.D . 1

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN
[redacted]

NEXT OF KIN'S ADDRESS
[redacted]

NEXT OF KIN'S CONTACT NUMBER
+ 8 6 [redacted]

1

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. 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 illness		✓		✓	

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.

2020/1/7
Date

[redacted]
Signature of candidate

创新创业学院
3415020102925

SECTION 2 – PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : 176 m	BLOOD PRESURE : 82/123 mmHg
WEIGHT : 83 kg	PULSE RATE : 86 /min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) 5.1 (L) 5.1	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. SYSTEM 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. MUSCULOSKELETAL SYSTEM	✓		

SECTION 3 – INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN	20/12/2019	Negative
b. SUGAR	20/12/2019	Negative
c. MICROSCOPIC	20/12/2019	Negative
d. MORPHINE	20/12/2019	Negative
e. CANNABIS	20/12/2019	Negative
f. AMPHETAMINES TYPES STIMULANT	20/12/2019	Negative

BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN	20/12/2019	Negative
b. HEPATITIS C	20/12/2019	Negative
c. HIV	20/12/2019	Negative
d. VDRL/THPA	20/12/2019	Negative
e. MALARIAL PARASITE	20/12/2019	Negative

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	DR: 100144356
DATE TAKEN	20/12/2019
PLACE TAKEN	Lu'an Hospital of traditional Chinese Medicine
REPORT	Examination of chese X-ray is normal

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date 2019.12.20 examined

Mr / Ms [redacted] Passport No. E [redacted]

and found him/ her

☑ IN GOOD HEALTH

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

☐ UNDERGOING TREATMENT FOR: (Please State)

Date 2020.1.7

Signature of Doctor :

Name of Doctor :

Qualification :

Hospital / Clinic Registration Number :

Official stamp :

Remarks By University/College Official :

5

安徽省六安市中医院

DR 检 查 报 告 单

姓　　名:[redacted]	性　　别:男	年　龄:31岁
送诊科室:慢性病门诊	送诊医生:薛金洲	床　号:
检查时间:2019-12-20 16:12	住 院 号:	DR　号:1[redacted]

检查部位: 胸部(正侧位)

DR描述:

胸廓对称，气管居中。双肺纹理增多。纵膈及肺门结构清晰，心影大小、形态属正常范围。双侧肋隔角锐利。

DR诊断:

双肺纹理增多，请结合临床。

报告医师: 李玲玲　　审核医师:　　日期:2019-12-20 16:18

安徽省六安市人民路
联系电话：0564-3597225
机器型号：DR

签字或盖章后生效，手写涂改作废
本诊断报告仅供临床医生参考