UNIVERSITI MALAYSIA PERLIS

GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT FOR POSTGRADUATE STUDENT

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.

2. MEDICAL CHECK UP IS COMPLUSORY FOR ALL FULL TIME STUDENTS.

3. PLEASE FILL IN THE FORM IN ENGLISH LANGUAGE.

4. PLEASE WRITE IN CAPITAL LETTERS.

5. THIS FORM HAS 2 SECTIONS

    - SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATES

    - SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR

6. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.

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

8. PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS.

9. PLEASE BRING ALONG THE CHEST X-RAY FILM AND REPORT FOR REGISTRATION ;

    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 3 MONTHS PRIOR TO REGISTRATION

10. MEDICAL CHECK UP AND CHEST X RAY WILL BE THE PROPERTY OF THE UNIVERSITY MALAYSIA PERLIS (UniMAP) AND CANDIDATES ARE NOT ENTITLED TO RE CLAIM THE DOCUMENTS.

11. UNIVERSITY ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN 3 MONTH BEFORE REGISTRATION.

12. 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 .

13. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO REJECT ANT 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 .

PIT 10

UNIVERSITI MALAYSIA PERLIS

HEALTH EXAMINATION REPORT

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
/

COURSE CODE

SEMESTER

FACULTY

MATRIC NO.

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT 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. 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 DISEASE			

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 SYSYTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

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

BLOOD TEST (FOR INTERNATIONAL STUDENTS ONLY)		
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 TREAMENT FOR: (Please State)

_____
_____
_____

Date: _____

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

Remarks By University Official:

SECTION 5 - AUTHORISATION FOR ANAESTHESIA AND SURGICAL PROCEDURE

Medical officer /Health Physician

University: _____

I : _____ Father/mother/guardian to applicant

_____I/C No. _____

I hereby authorize the medical officer to sign on my behalf for anaesthesia surgical procedure on the applicant In my absence , in the event of an emergency , as confirmed by the attending doctor , when required .

I will absolve the University of any responsibilities from any unfavourable consequences which may arise from the said procedure .

Name of Father/Mother/Guardian
_____

Yours faithfully
_____

Address :
_____
_____
_____
_____

Signature of Father/Mother/Guardian
_____

Telephone No.
_____

Date :
_____