HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIA HIGHER EDUCATIONAL INSTITUTIONS
马来西亚高等教育部体检表指导说明

1 PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM
在填写体检表之前请认真仔细阅读注意事项。

2 PLEASE FILL IN THE FORM IN ENGLISH
表格内容请用英文填写。

3 PLEASE WRITE IN CAPITAL LETTERS
请使用大写字母填写所有内容。

4 THIS FORM HAS 4 SECTIONS
该体检表共有4个主要部分

A) SECTION 1 (PART A & B) TO BE FILLED IN BY THE APPLICANT
第一部分中A,B两部分由申请人自行填写；

B) SECTION 2, 3 & 4 TO BE FILLED IN BY THE EXAMINNG DOCTOR
第二、三、四部分由体检医生填写。

5 PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM
请务必填写完所有检测项目。

6 THE UNIVERSITY / COLLEGE ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN 60 DAYS BEFORE REGISTRATION OR WITHIN 30 DAYS AFTER REGISTRATION
大学、学院只接受申请人在注册入学前60天内所做的身体检查报告，或在入学注册后30天内所做的身体检查报告。

7 PLEASE ATTACH ALL THE ORIGINAL LABORATORY RESULTS
请务必附上所有检查结果的原始文件。

8 PLEASE BRING ALONG CHEST X-RAY FILM AND REPORT FOR REGISTRATION
在你注册的时候请务必带上胸腔X-光片及X-光片的报告结果。

9 PLEASE ENSURE THE X-RAY FILM IS LABELLED WITH YOUR NAME AND DATE TAKEN (IN ENGLISH)
请确保X-光片上有你的名字以及取片时间。

10 CHEST XRAY DONE WITHIN 6 MONTHS PRIOR TO REGISTRATION CAN BE ACCEPTED
在申请注册入学前6个月之内所拍的X-光片是被认可的。

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
如大学或学院对学生的体检报告或体检报告内任一体检项目有疑问的，学校有权要求学生重新体检。同时所有检查费用均由学生承担。

12 THE UNIVERSITY/COLLEGE RESERVES THE RIGHT TO REJECT ANY APPLICATION.
如出现下列情况，学校有权拒绝办理学生入学注册申请：

A) BASED ON THE RESULTS OF THE HEALTH EXAMINATION OR
基于学生体检报告结果，发现学生体检不合格者；

B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS
如有任何证据表明学生提供虚假信息或隐瞒自身病情者。

LIMKOKWING UNIVERSITY OF CREATIVE TECHNOLOGY

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

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

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 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. MUSCULOSKELETAL 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

☐ 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 University/College Official :