VICTORIA INTERNATIONAL COLLEGE

Kuala Lumpur Campus
468-7B, 3rd Mile,
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Tel: +603-4043-1168
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Email: info@vicmy.com
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Rawang Campus
No.37, Jalan Hijau 5/3,
Bandar Tasik Puteri
48020 Rawang
Selangor Darul Ehsan
Tel: +603-6034-3052
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HEALTH EXAMINATION GUIDELINES FOR ENTRY INTO MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

Lampiran A

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 ALL THE TESTS REQUIRED IN THIS FORM.

6.THE UNIVERSITY / 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.

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passport size photo

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

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

Please complete in block letters and tick (✓) where applicable.

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

NAME OF RELATIVE

RELATIVE ADDRESS

RELATIVE CONTACT NUMBER

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 1 (PART B)

Please tick (✓) where applicable.

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses.
* Immediate family refer s 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 _____

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 2 - PHYSICAL EXAMINATION
To be filled by examining doctor

Please tick (✓) where applicable.

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			

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

SECTION 3 - INVESTIGATIONS

Please tick (✓) where applicable.

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	

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HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

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:

_____

_____