



卫理神学院 *Sekula Teologi Methodist*
Methodist Theological School

51, Jalan Tun Abang Haji Openg, 96007, Sibul, Sarawak, Malaysia.



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)

[illegible]

INTERNATIONAL PASSPORT NO.

[illegible]

NATIONALITY

[illegible]

CONTACT NUMBER

[illegible]

DATE OF BIRTH

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AGE

--	--

SEX

MALE

7

MARITAL STATUS

SINGLE

7

DDMMYY

FEMALE

7

MARRIED

7

ACADEMIC YEAR

--	--	--	--	--	--	--	--	--

S T U D E N T I D

[illegible]

PROGRAMME OF STUDY

[illegible]

PROGRAMME CODE

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NEXT OF KIN

[illegible]

NEXT OF KIN'S ADDRESS

[illegible]

NEXT OF KIN'S CONTACT NUMBER

[illegible]

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.

Date

Signature of candidate

SECTION 2 – PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____m	BLOOD PRESURE : _____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. 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		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPES STIMULANT		

BLOOD TEST		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL/THPA		
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. / 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 University/College Official :