KOLEJ GEMILANG (W4P0085)
NO 13,16,18 & 20 MEDAN PASAR 50050 KUALA LUMPUR
Tel: (603) 20729300 (HL) Fax: (603) 20264341
Web-site: gemilang.edu.my

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

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

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 illness.
* 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. Asthma					
8. Thyroid disease					
9. Kidney disease					
10. Hearth or vascular 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
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 approriate 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 :