Health Examination Report for International Student and Accompanying Person

SWINBURNE UNIVERSITY OF TECHNOLOGY SARAWAK CAMPUS

Health Examination Guidelines for entry into Swinburne University of Technology Sarawak Campus

Please read the instructions carefully before filling in the form.

1. This form has **4 sections**:
   (a) Section 1 (part A and B): to be filled by the Applicant
   (b) Section 2, 3 and 4: to be filled by the examining doctor
2. All information are to be provided in **English** language and in **CAPITAL** letters.
3. All tests that are stated in this form must be completed.
4. Only medical examination done within 60 days before enrolment date or within 30 days after enrolment date will be accepted.
5. All **original** laboratory results must be attached.
6. Chest **X-Ray film and report** must be presented for registration.
7. Name of Applicant and date of **X-Ray** taken must be indicated.
8. Chest X-Ray done within **6 months** prior to registration will be accepted.
9. Swinburne University of Technology Sarawak Campus reserves the right to **repeat** full medical check-up or any specific laboratory tests. All costs involved shall be borne by the Applicant.
10. Swinburne University of Technology Sarawak Campus 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.

PRINT YOUR NAME AS IT APPEARS IN YOUR NRIC/PASSPORT. Please use BLOCK LETTERS. All fields must be completed.

SECTION 1 PART A: PERSONAL DETAILS

Title (Mrs, Miss, Ms, Mr etc): _____

Full name:
(as indicated in passport)

Passport number:

Nationality:

Contact number:

Date of birth: D D / M M / Y Y Age: Sex: / Marital status: /
Single Married

Course applied:

Intake applied:

Next of Kin:

Next of Kin's address:

Next of Kin contact no.:

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	
Cogenital or inherited disorder					
Allergy					
Mental illness					
Fits, stroke, other neurological diseases					
Diabetes Mellitus					
Hypertension					
Asthma					
Heart or vascular disease					
Thyroid disease					
Kidney dsease					
Cancer					
Tuberculosis					
Drug addiction					
AIDS, HIV					
HIstory of surgery					
Hepatitis B and Sexually Transmitted Diseases					
Other illnesses					

Current medication (long term):

IMMUNIZATION HISTORY (Where applicable)	DATE IMMUNIZED				
Yellow Fever					
BCG					
Meningitis (Quadrivalent)					
Hepatitis B					
Others:					

GENERAL PRIVACY STATEMENT

The information collected on this form is to assess your application for entry onto a course at Swinburne University of Technology Sarawak Campus. It is also used to create an enrolment record for the University database, prepare statistical analysis and to inform you about your course and other courses and/or events. The information is processed in accordance with the Malaysian Personal Data Protection (PDP) Act 2010, It is only disclosed to third parties only with your consent or to meet statutory obligation.

For more information, please refer to the University's Privacy Policy at **http://www.swinburne.edu.my/privacy/.**

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.

Signature of applicant: _____ Date: D D / M M / Y Y

SECTION 2: PHYSICAL EXAMINATION

To be filled by examining doctor.

BASIC MEASUREMENT

Height:	meters	Blood Presure:	mmHg
Weight:	kg	Pulse Rate:	/min
Vision Test:	Unaided: (R) _____ (L) _____ Aided: (R) _____ (L) _____	Colour Vision Test:	Normal/Abnormal

GENERAL EXAMINATION

Item	Yes	No	Comment
Deformities			
Pallor			
Cyanosis			
Jaundice			
Oedema			
Skin disease			

SYSTEMATIC EXAMINATION

Item	Normal	Abnormal	Comment
Eyes (including funduscopy)			
Ears			
Nose			
Oral Cavity / Throat			
Neck			
Heart			
Lungs			
Abdomen / Hernia Orifices			
Nervous System			
Mental Condition			
Musculoskeletal System			

SECTION 3: INVESTIGATIONS

URINE TEST		
Item	**Date Taken**	**Results**
Albumin		
Sugar		
Microscopic		
Morphine		
Cannabis		
Amphetamines Type Stimulant		

BLOOD TEST		
Item	**Date Taken**	**Results**
Hepatitis B Antigen		
Hepatitis C		
HIV		
VDRL / TPHA		
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 relevant 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)

_____

_____

_____

Signature of Doctor: _____ Date: D D / M M / Y Y

Name of Doctor: _____

Qualification: _____

Hospital/Clinic
Registration Number: _____

Official Stamp: _____

REMARKS BY UNIVERSITY OFFICIAL