PLEASE USE CAPITAL LETTERS ***(SILA ISI MENGGUNAKAN HURUF BESAR)***

SECTION 1 (To Be Completed By Candidate) ***(SEKSYEN 1 –*** *Untuk Diisi Oleh Calon* ***)***

PART A ***(BAHAGIAN A)***

FULL NAME *(NAMA PENUH)*

IC. NO *(NO. K/P)*

AGE *(UMUR)* CONTACT NO. *(NO. TELEFON)*

GENDER *(JANTINA)* M F

MARITAL STATUS *(STATUS PERKAHWINAN)* SINGLE *(BUJANG)* MARRIED *(BERKAHWIN)*

DATE OF BIRTH *(TARIKH LAHIR)*

D D M M Y Y Y Y

PROGRAMME *(KURSUS)*

NEXT OF KIN'S / GUARDIAN'S NAME *(NAMA SAUDARA TERDEKAT / PENJAGA)*

NEXT OF KIN'S ADDRESS *(ALAMAT SAUDARA TERDEKAT)*

NEXT OF KIN'S CONTACT NO. (FOR EMERGENCY) *(NO. TELEFON SAUDARA TERDEKAT (UNTUK KECAMASAN))*

RELATIONSHIP *(HUBUNGAN)*

PART B *(BAHAGIAN B)*

Declaration of self illness. *(Pengisytiharan tahap kesihatan diri sendiri)*

Please tick (√) in the relevant box *(Sila tandakan (√) di dalam kotak yang berkenaan)*

No	Medical Problems *(Masalah Kesihatan)*	Yes	No	*If 'Yes' please give details *(Jika 'Ya' sila beri butiran)*
1	Congenital or inherited disorder			
2	Allergies			
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	Prior Surgeries			
16	Other illnesses			

* Detail may be included in a separate sheet. *(Butiran boleh disertakan dalam helaians berasingan)*

No	Immunization History (where applicable) *(Rekod Imunusasi (jika berkenaan))*	Date of Immunization *(Tarikh Imunisasi)*
1	BCG	
2	Pertussis	
3	Poliovirus	
4	Diphtheria	
5	Tetanus	
6	Mumps	
7	Rubella	
8	Measles	
9	Hepatitis B	
10	Varicella (Chicken Pox)	
11	Meningococcal ACWY	
12	COVID-19 Vaccine	
13	COVIC-19 Booster	
	Others	

I hereby certify that the information given above to the MEDICAL EXAMINER is true.

Saya dengan ini memperakui bahawa maklumat yang diberikan kepada PENGAMAL PERUBATAN di atas adalah benar.

Signature of candidate and Date *(Tandatangan Pelajar dan Tarikh)*

(To be signed in the presence of the Medical Examiner)*(Ditandatangani di hadapan Pemeriksa Perubatan)*

SECTION 2 - PHYSICAL EXAMINATION (PEMERIKSAAN FIZIKAL)

To be filled by examining doctor *(Diisi oleh pengamal perubatan)*

1. BASIC MEASUREMENT

HEIGHT	: _____ m		BLOOD PRESSURE	: _____	mmHg
WEIGHT	: _____ kg		PULSE RATE	: _____	/ min
BMI	: _____ kg/m2		WAIST CIRCUMFERENCE	: _____	cm
VISION TEST (Unaided)	: (R) _____ (L) _____		(Aided) : (R) _____ (L) _____		
COLOR VISION TEST	: Normal / Abnormal (Please specified) _____				
BLOOD GROUP	: _____		_____		
	_____		_____		

2. GENERAL EXAMINATION

ITEM	NORMAL	ABNORMAL	*If Abnormal, please give details
1. Respiratory System			
Nose			
Chest Expansion			
Pharynx			
Lungs Right			
Lungs Left			
2. Circulatory System			
Pulse			
Blood Pressure			
Heart			
3. Alimentry System			
Appetite			
Digestion			
Bowels			
Teeth			
Tongue			
Spleen			
Liver			
Rupture			
Heamorrhoids			
4. Nervous System			
Sight Right			
Sight Left			
Reflexes			
Hearing			
5. Reproductive System			
Varicocolae			
Syphilis			
6. Urinary System			
Specific Gravity			
Albumin			
Sugar			
Deposit			
Miscellaneous			

SECTION 3 - CERTIFICATION BY THE EXAMINING DOCTOR

I certify that I have examined Mr/Ms _____

NRIC No. _____ and found him / her :

☐ In Good Health

☐ Having the following health related issue/s (please state)

_____

_____

_____

_____

☐ Undergoing treatment for (please state)

_____

_____

_____

Signature of Doctor : _____

Name of Doctor : _____

Address : _____

_____

_____

Date : _____

Official Stamp

Remark by College Official :