



卫理神学院 Sekula Teologi Methodist Methodist Theological School

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

Passport size phoro

PLEASE USE CAPITAL LETTERS		
SECTION (To be completed by cand (PARTA)	didate)	
FULL NAME (AS IN PASSPORT)		
INTERNATIONAL PASSPORT NO.		
NATIONALITY	CONTACT NUMBE	R
DATE OF BIRTH AGE	. MALE S	MARITAL STATUS
	14	MATTICE .
ACADEMIC YEAR 8	TUDENT ID	
ACADEMIC YEAR S		***************************************
ACADEMIC YEAR S' PROGRAMME OF STUDY		
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PROGRAMME OF STUDY	TUDENT ID	
PROGRAMME OF STUDY NEXT OF KIN	TUDENT ID	
PROGRAMME OF STUDY NEXT OF KIN	TUDENT ID	

(PART B) - Please tick (√) in the relevant box

3. Meningitis (Quadrivalent)

Hepatitis B
 Others:

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

		SELF		IMMEDIATE FAMILY		If "Yes", please state.
	MEDICAL PROBLEMS	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					
۲.	Thyroid disease					
10.	Kidney disease					
11.	Cancer					
12.	Tuberculosis					
13.	Drug addiction					
14.	AIOS, HIV	•				
15.	History of surgery					
16.	Other illnesses					

Current medication (Long term)	•
	*
IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED
Yellow Fever	

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

BASIC MEASURE	MENT		1 5
HEIGHT :	m .	BLOOD PRESSURE :mm	nHg
WEIGHT :	kg	PULSE RATE : /m	nin
VISION TEST : Unaid	led: (R)(L)	COLOUR VISION TEST :	
Aideo	: (R)(L)	NORMAL / ABNORMAL	

GENERAL EXAMINATION			and the second s
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			4
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
T. SKIN DISEASES			

SYSTEMIC EXAMINATION) ! 	and the state of t
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		1	
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		

Е	BLOOD TEST		Contract Con
	ITEM	DATE TAKEN	RESULT
a.	HEPATITIS Bs ANTIGEN		
ъ.	HEPATITIS C		
C.	HIV		
d.	VDRL / TPHA		
æ.	MALARIAL PARASITE		,

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN.	·
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR Please tick (0) in the appropriate box 1 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) Signature of Doctor Date Name of Doctor Qualification Hospital / Clinic Registration Number Official stamp Remarks By University/College Official: