JPA/BMI/KESIHATAN

CONFIDENTIAL **PROGRAMME : PPKP**

HUMAN CAPITAL DEVELOPMENT DIVISION

Bahagian Pembangunan Modal Insan

PUBLIC SERVICE DEPARTMENT (PSD)

Jabatan Perkhidmatan Awam (JPA)

HEALTH DECLARATION AND MEDICAL EXAMINATION FORM

Borang Pengakuan dan Pemeriksaan Kesihatan

Instruction : (Kindly use Black ink ball pen to fill up this form)

(i) Health Declaration - to be completed by student
(ii) Medical Examination - to be completed by certified physician

Note : Student is responsible to return this form to PSD once completed

Arahan : (Sila gunakan pen mata bola berdakwat HITAM sahaja untuk mengisi borang ini)

(i) Pengakuan Kesihatan - diisi oleh pelajar
(ii) Pemeriksaan Kesihatan - diisi oleh pegawai perubatan bertauliah

Nota :Pelajar adalah bertanggungjawab untuk mengembalikan borang yang telah lengkap diisi ke JPA

***Pemeriksaan kesihatan untuk kanak-kanak dan bayi, bergantung kepada keperluan yang ditentukan oleh Pegawai Perubatan yang berkenaan.**

***For children and babies, the Medical Officer can determine which particular medical checkup is relevant and valid.**

PERSONAL DETAILS
Maklumat Peribadi

Name *Nama*	**I.C. No** *No.KP*	**Date of Birth** *Tarikh Lahir* / /

Sex : M [ ] F [ ] Marital Status : Single [ ] Married [ ] Other :_____
Jantina L P Status Perkahwinan Bujang Berkahwin Lain-lain

Home Address *Alamat Kediaman*	**Contact Number** *No untuk dihubungi* **(H)R :** **(H/P) I.B :**

Name, relationship and address of next of kin *Nama hubungan dan alamat waris*	**Contact Number** *No untuk dihubungi* **(H)R :** **(H/P) I.B :**

HEALTH DECLARATION

Pengakuan Kesihatan

Have you or your family members ever suffered any of the following conditions?

Pernahkah anda atau keluarga terdekat mengalami masalah-masalah kesihatan berikut?

Please mark X in an appropriate column/ *Tandakan X di ruang berkenaan*

		Student *Pelajar*		**Family Member** *Ahli Keluarga*	
SN	**ILLNESS**	**YES**	**NO**	**YES**	**NO**
1.	**Psychiatric illness / *(Sakit Jiwa)***				
2.	**Epilepsy / *(Sawan)***				
3.	**Migraine / *(Migrain)***				
4.	**Hysteria /*(Histeria)***				
5.	**Allergic Rhinitis / *(Resdung)***				
6.	**Asthma / *(Lelah)***				
7.	**Tuberculosis (PTB) / *(Batuk Kering)***				
8.	**Hypertension (HPT) / *(Darah Tinggi)***				
9.	**Diabetes Mellitus (DM) / *(Kencing Manis)***				
10.	**Heart Diseases / *(Penyakit Jantung)***				
11.	**Thyroid Diseases / *(Penyakit Tiroid)***				
12.	**Kidney Diseases / *(Penyakit Buah Pinggang)***				
13.	**Gastric / *(Penyakit Gastrik)***				
14.	**HIV / AIDS**				
15.	**Cancer / *(Barah)***				
16.	**Venereal Diseases / *(Penyakit Kelamin)***				
17.	**Leukemia / *(Leukimia)***				
18.	**Hepatitis / *(Hepatitis)***				
19.	**Blood Stained Sputum *(Kahak Berdarah)***				
20.	**Other Lung Diseases/ (*Lain-lain Penyakit Paru-Paru)***				
21.	**Joint Pain /(*Sengal-sengal sendi)***				
22.	**Swelling of Legs /(*Bengkak Kaki)***				
23.	**Giddines*/(Pening Kepala*)**				
24.	**Hernia*/(Burut)***				
25.	**Drug Addiction*/(Ketagihan Dadah***				
26.	**Allergic/ *(Alahan)***				
27.	**Surgical Operation/(*Pembedahan)***				
28.	**Disability or Handicap/(*Kecacatan)***				

If yes, please give details *(Jika Ya, sila nyatakan butiran lanjut)*

_____

_____

_____

_____

_____

Please State (Sila nyatakan)

Other illnesses / *(Penyakit-penyakit lain)*

_____

Operation/Surgical (Minor/Major) / *(Pembedahan Besar/ Kecil)*

_____

Details of Allergies / *(Butiran lanjut mengenai Alahan)*

_____

Family Medical History/ *(Sejarah Kesihatan Keluarga)*

_____

Details of Disability/Handicap/ *(Butiran lanjut mengenai Kecacatan)*

_____

History of Blood Transfusion / (*Sejarah Perpindahan Darah*)

Number of Transfusion	Date of Transfusion	Amount Transfused	Reasons for Transfusion

Please mark X in an appropriate column / *Tandakan X di ruang berkenaan.*

Smoking : ☐ YES/Ya ☐ NO/*Tidak*
Merokok

If yes : a) Duration/*Tempoh* : ……Year /*Tahun*
b) No. of sticks per day/*Jumlah batang rokok sehari* : ……

I hereby certify that the above information are true and complete, and agree that any misrepresentation or deliberate omissions of a material fact on this form may result in me not being permitted to enter a program, or may result in termination and I will be required to pay back the whole expenses incurred by PSD. I hereby grant The Human Capital Division, PSD permission to share information contained herein with relevant authorities.

Saya dengan ini mengaku maklumat di atas adalah benar dan lengkap dan bersetuju sekiranya terdapat maklumat yang tidak benar atau dengan sengaja tidak menyatakan perihal sebenar di dalam borang ini akan menyebabkan saya tidak dibenarkan mengikuti program yang ditawarkan, atau menghadapi kemungkinan ditamatkan daripada program dan dituntut perbelanjaan sebenar. Saya dengan ini memberi kebenaran kepada Bahagian Pembangunan Modal Insan, JPA untuk berkongsi maklumat yang terdapat di dalam Borang Pemeriksaan Kesihatan saya dengan pihak-pihak yang berkenaan.

X_____ _____
Signature/ *Tandatangan* Date/ *Tarikh*

CONFIDENTIAL

MEDICAL EXAMINATION

(The Physician must complete all questions, give additional comment where necessary and responsible for the information, suggestion and recommendation regarding the student's health given in this form)

Student Name and I.C. Number **Date of Birth**

/ /

PHYSICAL EXAMINATION

WEIGHT	HEIGHT
BLOOD PRESSURE	PULSE

VISION

Acuity Test		R	L
	Without glass		
	With glass		

Colour Test :

Are there abnormalities of the following systems? If yes, describe fully using additional sheet if necessary

<table>
<tr><th></th><th>SYSTEMS</th><th>Normal</th><th>Abnormal (Please provide additional information)</th></tr>
<tr><td>1</td><td>Skin</td><td></td><td></td></tr>
<tr><td>2</td><td>Ear Nose Throat</td><td></td><td></td></tr>
<tr><td>3</td><td>Cardiovascular</td><td></td><td>BP
Pulse
Rhythm
Heart Murmur</td></tr>
<tr><td>4</td><td>Respiratory</td><td></td><td></td></tr>
<tr><td>5</td><td>Gastrointestinal</td><td></td><td></td></tr>
<tr><td>6</td><td>Genitourinary (incl. Venereal Diseases such as HIV/AIDS)</td><td></td><td></td></tr>
<tr><td>7</td><td>Central and Peripheral Nervous System</td><td></td><td>
<table>
<tr><td></td><td colspan="2">Upper limb</td><td colspan="2">Lower limb</td></tr>
<tr><td></td><td>L</td><td>R</td><td>L</td><td>R</td></tr>
<tr><td>Power</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Reflexes</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Others</td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>8</td><td>Psychiatric (Mental State Examination)</td><td></td><td></td></tr>
<tr><td>9</td><td>Lymphatic System</td><td></td><td></td></tr>
<tr><td>10</td><td>Reproductive system</td><td></td><td>If case of pregnancy, please provide further details:
Last Menstrual Date =
Period of Amenorrhea =
Expected Date of Delivery =</td></tr>
</table>

A. INVESTIGATIONS:

ALL TESTS LISTED BELOW ARE MANDATORY:

<table>
<tr><th>SN</th><th>TESTS</th><th>RESULTS</th></tr>
<tr><td>1.</td><td>Urine</td><td>For All candidates

URINE TEST
<table>
<tr><td>NAD</td><td></td><td>WBC</td><td></td><td>RBC</td><td></td></tr>
<tr><td>PROTEIN</td><td></td><td>GLUCOSE</td><td></td><td>DRUG</td><td></td></tr>
</table>
For Ladies only:
Pregnancy test (for ladies only) –

PREGNANCY TEST
<table>
<tr><td>POSITIVE</td><td></td><td>NEGATIVE</td><td></td></tr>
</table></td></tr>
</table>

2.	Chest X-Ray	

3.	Blood		Positive	Negative
		HEPATITIS B		
		HIV/AIDS		
		VDRL		
		TPHA		

4.	Mantoux test	(For candidate who study in USA only)

Other discretionary tests undertaken if necessary:

TESTS	RESULTS

Is the student now under treatment for any physical or emotional condition?

_____

By history and physical examination, is this student a carrier of any communicable disease?

_____

B. RECOMMENDATION:

Medically fit	
Medically fit with limited capability	Please explain.
Medically Not fit	Please explain.

I hereby certify that I have examined _____ I/C No._____ including x-ray and I confirmed that the candidate is ***MEDICALLY FIT/ UNFIT (*delete where appropriate)** to enter the program.

PHYSICIAN'S FULL NAME: *:* _____

NO. K/P (I/C NO.) *:*_____

POST AND QUALIFICATION *:*_____

COP RASMI (OFFICIAL SEAL) *:*_____

X_____ _____

PHYSICIAN'S SIGNATURE ***DATE***

Note : In completing this form, particular attention should be paid to the following points :-

(a) X-ray of chest to rule out any tuberculosis or chronic pulmonary disease: where the film is entirely normal it needs not be forwarded but if any abnormality is noted the film should be sent with this report.

(b) Kidneys – no evidence of renal lesion should be present

(c) Eyesight – severe errors of refraction should be not passed as these should only give trouble during the years of study.

(d) Hearing – deafness be considered a definite bar.