

## HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

### SECTION 1 (PART B)

Declaration of self and family illness. Explain in full if you or your immediate\* family has any of the following illnesses. \* Immediate family refers to mother, brothers / sisters.

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Congenital or Inherited Disorder		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
2. Allergy		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
3. Mental Illness		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
4. Fits, Stroke, Other Neurological Disease		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
5. Diabetes Mellitus		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
6. Hypertension		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
7. Heart or Vascular Disease		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
8. Asthma		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
9. Thyroid Disease		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
10. Kidney Disease		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
11. Cancer		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
12. History of Surgery		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
13. Tuberculosis (TB)		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
14. HIV / AIDS		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
15. Hepatitis B		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
16. Sexually Transmitted Diseases		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
17. Drug Addiction		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
18. Other Illnesses		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	

Current medication (Long Term)

VACCINATION HISTORY (where applicable)	Yes	No	Date of Vaccination
1. Yellow Fever			
2. BCG			
3. Meningitis (Quadrivalent)			
4. Hepatitis B			
5. Polio			
6. Measles			
7. Rubella			
8. Others: (specify)			

Notes :

- \*A valid Yellow Fever vaccination certificate is required from all travellers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
- All students are required to take vaccines as listed in numbers 2-7 above.
- The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

