



KARNIVAL SUKAN MASUM FASA 1, 2020

UNIVERSITI TEKNOLOGI MARA

30 JANUARI HINGGA 6 FEBRUARI 2020

Majlis Sukan Universiti Malaysia
Kementerian Pendidikan Malaysia
Aras 2, No.2, Menara 2, Jalan P5/6
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UNIVERSITI
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MARA

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STUDENT MEDICAL HEALTH REPORT

Name: _____ Metric No : _____

MEDICAL SELF-DECLARATION TICK (/) AT APPROPRIATE BOX

Have you contacted or receiving treatment for the following illness:

	Yes	No
i. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
ii. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
ii. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
iv. Diabetics	<input type="checkbox"/>	<input type="checkbox"/>
v. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
vi. Disfigurement	<input type="checkbox"/>	<input type="checkbox"/>

STUDENT DECLARATION

I _____ I.C No. _____

hereby declare that all information declared are truthful.

Date: _____

Student's signature in the presence of doctor _____

DOCTOR'S MEDICAL REPORT

1. Brain alertness	Ordinary <input type="checkbox"/>	extraordinary <input type="checkbox"/>				
2. Heat Beat	3. Blood Pressure	<table border="1"> <tr><td>Sistolic MmHg</td><td><input type="checkbox"/></td></tr> <tr><td>Diastolic MmHg</td><td><input type="checkbox"/></td></tr> </table>	Sistolic MmHg	<input type="checkbox"/>	Diastolic MmHg	<input type="checkbox"/>
Sistolic MmHg	<input type="checkbox"/>					
Diastolic MmHg	<input type="checkbox"/>					
4. Heart	Ordinary <input type="checkbox"/>	Extraordinary <input type="checkbox"/>				
5. Lung	Ordinary <input type="checkbox"/>	Extraordinary <input type="checkbox"/>				
6. Abdomen	Ordinary <input type="checkbox"/>	Extraordinary <input type="checkbox"/>				

Comment : _____

I hereby declare that the student :-

<input type="checkbox"/>	Does not suffer from any illness, certified healthy and fit to take part in Karnival Sukan MASUM Fasa 1, 2020	
<input type="checkbox"/>	Suffer illness of _____	and allowed/ not allowed to take part in Karnival Sukan MASUM Fasa 1, 2020.

STAMP

Doctor's Name		Singnature
Department		
Date		