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**Visiting Scholar Medical Information Form**  
To be completed and signed by the candidate's physician

Name of Candidate (Mr.) (Ms.) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

An overseas program can create serious emotional and physical stress for those not able to meet the demands of living in a totally different environment for an extended period of time. This form will be on file in the Shansi Office and be made available to the physician in Oberlin.

- The general state of health is \_\_\_excellent \_\_\_good \_\_\_fair \_\_\_poor.
- Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration? YES\_\_\_ NO\_\_\_ If yes, explain\_\_\_\_\_

3. Check YES or NO: Has the candidate had the diseases/conditions listed below:

	Yes	No	If known		Yes	No
Measles	___	___	___ Titer___date___	Rheumatic Fever	___	___
Mumps	___	___	___ Titer___date___	Cough (persistent, recurring)	___	___
Rubella	___	___	___ Titer___date___	Headaches (persistent)	___	___
Chicken Pox	___	___		Poliomyelitis	___	___
Hepatitis	___	___		Appendicitis	___	___
Tuberculosis	___	___		Parasites (intestinal)	___	___

If yes, give detailed information and dates (use extra pages if necessary)\_\_\_\_\_

4. ALLERGIES YES\_\_\_ NO\_\_\_ If yes identify area, severity, any medication taken, name dosage and frequency. \_\_\_\_\_

5. ASTHMA YES\_\_\_ NO\_\_\_ If yes, identify type and severity, medication taken, name, dosage and frequency. \_\_\_\_\_

6. DIABETES YES\_\_\_ NO\_\_\_ If yes, identify type and severity, medication taken, name, dosage and frequency. \_\_\_\_\_

7. SEIZURE DISORDER YES\_\_\_ NO\_\_\_ If yes, identify type and severity, medication taken, name, dosage and frequency. \_\_\_\_\_

Oberlin Shansi Visiting Scholar Medical Information Form

8. Has the candidate ever had any disease, impairment or abnormality of:

	Yes	No		Yes	No
Abdominal organs, digestive system	___	___	Heart or blood vessels	___	___
Lungs, respiratory system	___	___	Tonsils, nose or throat	___	___
Bones, joints, loco-motor system	___	___	Blood, endocrine system	___	___
Genitor-urinary system	___	___	Eyes/vision, ears/hearing	___	___

If yes, give detailed information and dates (use extra pages if necessary)\_\_\_\_\_

9. Has the candidate ever been hospitalized YES\_\_\_ NO\_\_\_ If yes give dates, diagnosis and outcome for each incident.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Is the candidate currently taking medications or injections (other than those previously mentioned)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To your knowledge, are there any medical or emotional factors affecting the applicant that may require treatment abroad?

Yes\_\_\_ No\_\_\_

Are there reasons the applicant should not travel abroad? If yes, please comment briefly on a separate sheet.

Yes\_\_\_ No\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Professional Qualification

\_\_\_\_\_

\_\_\_\_\_  
Address