PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

This form is to be completed and signed by your physician by JUNE 1. All information must be in English.

Scan and email form to Health-forms@rhodes.edu by June 1

Student's Name_____ Birthdate_____ Rhodes ID_____

Height_____ Weight_____ Pulse_____ BP_____/_____

Assess the following systems:

	Normal	**Abnormal**	**Explanation of Abnormality**
Eyes			
Ears			
Nose			
Throat			
Mouth			
Dental			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Skin			
Genitalia			
Menstrual History (if applicable)			
Hernia	No	Yes	
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Do you consider this student physically and emotionally fit to undertake a college career? _____
If the student is unfit in any way, what restrictions or correction would you advise?_____

_____

Is the student able to participate in athletics or physical education? **Yes** or **No**
If the student is deemed unable, please explain why.

_____

_____

***ALL FIRST YEAR VARSITY COLLEGIATE ATHLETES MUST HAVE AN EKG AND A SICKLE CELL SOLUBILITY TEST AS PART OF THEIR PHYSICAL. PLEASE ATTACH A COPY OF THE EKG AND REPORT AND THE SICKLE CELL TEST RESULT WITH THE PHYSICAL FORM.**

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REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YR)
1. TETANUS-DIPHTHERIA-PERTUSSIS (required for all students) dT booster within 10 years…… OR Tdap within past 10 years……..	_____-_____-_____ OR _____-_____-_____
2. M.M.R. (MEASLES, MUPMS, RUBELLA) (required for all students) (Two doses required at least 28 days apart for students born after 1956) 1. Dose 1 given at age 12 months or later……. 2. Dose 2 given at least 28 days after first dose…….	#1_____-_____-_____ #2_____-_____-_____
3. MENINGOCOCCAL (required for all students) A minimum of 1st dose given at 16 years or greater Should be repeated every 5 years if risk persists (i.e. travel needs)	Menactra ---------- _____OR Menomune ---------- _____ Serogroup B ---------- _____
4. VARICELLA (required for all students) History of disease Yes□ No□ If No History of Disease: 1. Varicella Antibody Titer ---------- ____Result: Positive____Negative____ OR 2. Immunization required if titer negative and no disease history Dose #1…… Dose #2 given at least 4 weeks after 1st…….	#1_____-_____-_____ #2_____-_____-_____

5. TUBERCULIN SKIN TEST (TBST) (required for all students)

(TBST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given:____/____/____Date Read:____/____/____

M D Y M D Y

Result:_____mm of induration Interpretation: positive____negative____

Examining Health Care Provider Name (Print)_____

Address_____

City_____State_____Phone_____

Signature of Examining Health Care Provider_____Date_____