



**PHYSICAL EXAMINATION AND IMMUNIZATION RECORD**

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**This form is to be completed, signed and stamped by a medical provider (MD, NP, PA) by July 15, 2026. All information must be in English and uploaded to your Elation Passport. If you have not received an invitation to join your Elation Passport, please email health@rhodes.edu or call (901) 843-3895.**

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ (mm/dd/yyyy)

Rhodes ID: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

Assess the Following Systems	Normal	Abnormal	Explanation of Abnormality
Eyes			
Ears			
Nose			
Mouth			
Dental			
Throat			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Hernia	No	Yes	
Genitalia			
Menstrual History (if applicable)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulders/Arms			
Elbows/Forearms			
Wrists/Hands/Fingers			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet/Toes			

Do you consider this student physically and emotionally fit to undertake a college career? Yes or No  
If the student is unfit in any way, what restrictions or corrections 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. \_\_\_\_\_

\_\_\_\_\_

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Required Immunizations	Date of Administration (MM/DD/YYYY)
<b>1. TETANUS-DIPHTHERIA-PERTUSSIS (required for all students)</b> dT Booster within 10 years..... OR Tdap within past 10 years.....	____ / ____ / ____  <b>OR</b> ____ / ____ / ____
<b>2. M.M.R. (MEASLES, MUMPS, RUBELLA) (required for all students)</b> (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 ____ / ____ / ____
<b>3. MENINGOCOCCAL (required for all students)</b> A minimum of 1 <sup>st</sup> dose given at 16 years or greater Vaccine should be repeated every 5 years if risk persist (i.e. travel needs)	Menactra--_____ <b>OR</b> Menomune--_____ Serogroup B-_____ (MM/DD/YYYY)
<b>4. VARICELLA (required for all students)</b> History of disease: Yes or No Student must have titer. 1. Varicella Antibody Titer Date: _____(MM/DD/YYYY) Positive                      Negative <b>OR</b> 2. Immunization required if titer negative and no disease history Dose #1..... Dose #2 given at least 4 weeks after 1 <sup>st</sup> .....	#1 ____ / ____ / ____ #2 ____ / ____ / ____
<b>5. TUBERCULIN SKIN TEST (TBST) (required for all students)</b> 1. Date Given ____ / ____ / ____ Date Read ____ / ____ / ____ (MM/DD/YYYY) Results: _____ mm of induration Interpretation: Positive Negative (TBST results 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.) 2. QuantiFERON -TB Gold Test Date: ____ / ____ / ____ (MM/DD/YYYY) Results: Positive Negative <b>(Students who have received a BCG vaccination are required to have this test or a chest xray performed in the United States).</b> 3. Chest Xray Date: ____ / ____ / ____ (MM/DD/YYYY) Results: Positive Negative	

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Examining Health Care Provider Name (Print): \_\_\_\_\_

Clinic Name and Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature and Stamp of Examining Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_