Rhodes College
STUDENT HEALTH CENTER

PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

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			
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)
1. TETANUS-DIPTHERIA-PERTUSSIS (required for all students) dT Booster within 10 years…… OR Tdap within past 10 years……..	_____/____/_____ **OR** _____/_____/_____
2. M.M.R. (MEASLES, MUMPS, 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 Vaccine should be repeated every 5 years if risk persist (i.e. travel needs)	Menactra--_____ **OR** Menomune-- _____ Serogroup B-_____ (MM/DD/YYYY)
4. VARICELLA (required for all students) History of disease: ☐ Yes or ☐ No Student must have titer. 1. Varicella Antibody Titer Date: _____(MM/DD/YYYY) 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) 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 ☐ **(Students who have received a BCG vaccination are required to have this test or a chest xray performed in the United States).** 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: _____