**RHODES IMMUNIZATION RECORD**

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This form MUST be completed and signed by your physician. All information must be in English.

Return this form to Rhodes College, Student Health Center

2000 N. Parkway, Memphis, TN 38112

Health-forms@rhodes.edu

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rhodes I.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| REQUIRED IMMUNIZATIONS | DATE AMINISTERED (MM/DD/YR) |
| 1. TETANUS-DIPHTHERIA-PERTUSSIS (required for all students)   **dT booster within 10 years………………………………………………**  OR  **Tdap within past 10 years………………………………………………..** | \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  **OR**  \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ |
| 1. HEPATITIS B   **Dose #1…………………………………………………………………..**  **Dose #2 (1-2 mo after 1st)……………………………………………….**  **Dose #3 (4-6 mo after 1st)……………………………………………….** | **#1**\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  **#2**\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  **#3**\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ |
| 1. M.M.R. (MEASLES, MUPMS, RUBELLA)   **(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**\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ |
| 1. MENINGOCOCCAL (vaccination required)   **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** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ |
| 1. POLIO (primary series required for all students)   **Date of last dose…………………………………………………………** | **□IPV**  \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ **□OPV** |
| 1. VARICELLA   **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 \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_** |
| 1. TUBERCULIN SKIN TEST (TST)   (TST 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 Physician**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_