Colorado State University New Student Immunizations Form

A. To be completed by student

Name: _____ DOB: / /

Last First Middle Initial Month/Day/Year

Address: _____

Street Address City State Zip Code Country

CSU ID #: _____ Phone Number: _____

Section B must be completed by your health care provider.

B. Required Immunizations

MMR Requirement: Two doses of measles, mumps, and rubella (MMR) vaccination are required. The first MMR cannot be accepted by the institute if it was given earlier than four days before the student's 1st birthday. The second dose of MMR must be given at least 28 days after the first dose of MMR. A positive MMR titer result may be submitted in lieu of vaccination history (attach copy of titer result).

Meningococcal (ACWY) Requirement: All students living on campus in student housing must provide documentation of receiving a Meningococcal ACWY vaccine within the last 5 years, OR they must read and sign the "Information Regarding MENINGOCOCCAL DISEASE" online waiver (see page 1 of form instructions for information on how to access online form.)

Vaccine Name:	Month/Day/Year Administered	Month/Day/Year Administered	Month/Day/Year Titer Date and Result
MMR (Measles, Mumps, Rubella)			
Measles			
Mumps			
Rubella			
Meningococcal (ACWY)			

OR

Call the CSU Health Network Immunizations Department at **(970) 491-7121** and request access to the online waiver titled "Information Regarding Meningococcal Disease." If student is under age 18, a paper form must be signed by a parent or legal guardian.

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Sections C and D must be completed and signed by your health care provider.

C. Recommended Immunizations (Stongly recommended for college students but not required by Colorado law)

Vaccine Name:	Month/Day/Year Administered					Titer Date and Result
COVID-19	Manufacturer:					
DTaP						
Td						
Tdap						
OPV/IPV (Polio)						
Hep A						
Hep B						
Varicella (Chickenpox)						
Men B						
HPV						
Other:						

D. Signature/Stamp of Health Care Provider. An official stamp from a doctor's office, clinic or health department AND/OR an authorized signature must appear here or this form will not be approved.

Health Care Provider Signature: _____ Date: _____ Stamp: _____