CSU HEALTH NETWORK
COLORADO STATE UNIVERSITY

Colorado State University New Student Immunizations Form

A. To be completed by student

Name: ______ Last ______ First ______ Middle Initial   DOB: ___ / ___ / ___ Month/Day/Year

Address: ______ Street Address ______ City ______ State ______ Zip Code ______ Country

CSU ID #: ____________________   Phone Number: ____________________

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

B. Required Immunizations

Vaccine Name:	Month/Day/Year Administered	Month/Day/Year Administered	Month/Day/Year Administered OR Titer Date and Result
MMR (Measles, Mumps, Rubella)			
Measles			
Mumps			
Rubella			
Meningococcal (ACWY)			—
COVID-19 Vaccine Manufacturer: ________			Booster Date and Manufacturer:

For information on MMR, Meningococcal, and COVID-19 vaccine exemptions, visit health.colostate.edu/new-student-checklist/#immunizations

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

Vaccine Name:	Month/Day/Year Administered					Titer Date and Result
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: ____________________