

**Depo-Provera Order**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name DOB

**Depo-Provera 150mg IM every 3 months for one year**.

Last Injection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Site

If performed: Last PAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, OR

Date

Last Vaginal Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Provider Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Provider Phone # Fax #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHC Provider Signature Date

**Please note:**

* **A yearly medication order or renewal is due prior to medication administration at the SHC.**
* **The student must hand carry the medication to the Health Center appointment.**

**Return completed form to:**

324 Kehr Union ● Commonwealth University - Bloomsburg ● 400 East Second Street ● Bloomsburg, PA 17815-1301

Phone: (570) 389-4451/4452 ● FAX: (570) 389-3417

*A Member of The Pennsylvania’s State System of Higher Education* **5/2024**