Bloomsburg LOCK HAVEN MANSFIELD
COMMONWEALTH UNIVERSITY OF PENNSYLVANIA

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
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