Student Health Center

Depo-Provera Order

Date ________________ Cell # ________________ BU 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 Physician's Signature Date

________________ ________________
Physician's Phone # Fax #

________________________________ ________________
BUSHC Medical Director's Signature Date

Please note:

- **A yearly order is due at the beginning of each fall semester.**
- **The first dose must be given by the prescribing provider.**
- **The student must hand carry the medication to the Health Center appointment.**

Return completed form to:

324 Kehr Union • Bloomsburg University • 400 East Second Street • Bloomsburg, PA 17815-1301
Phone: (570) 389-4451/4452 • FAX: (570) 389-3417
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