



## Contraceptive Approval Form

\_\_\_\_\_ was examined by me on \_\_\_\_\_  
(Patient Name) (date of birth) (exam date mm/dd/yyyy)

I approve her use of **(circle one)** through \_\_\_\_\_, \_\_\_\_\_.  
(month) (year)

**Ortho Evra**

**Nuvaring**

**\*Oral Contraceptive:** \_\_\_\_\_  
\*(name of pill)

**Depo Provera:** \_\_\_\_\_  
(date of last injection)

**\*The Student Health Service may substitute reasonably equivalent oral contraceptive products if the prescribed OCP is not on our formulary.** Another examination will be needed for contraceptive approval beyond the date listed above.

Clinician Signature \_\_\_\_\_

Type or print name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Please Fax completed form to the Student Health Service at (715) 836-5979.

OR: mail to student at: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ATTENTION STUDENT:** An appointment must be made to purchase birth control pills at the Student Health Service by calling 836-5360.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_