

**CAL STATE SAN MARCOS
STUDENT HEALTH SERVICES
CONSENT FOR PROVISION OF HORMONAL BIRTH CONTROL METHOD**

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you.

I have been given information about the contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications and alternate choices.

I have been advised of possible danger or warning signs of utilizing a contraceptive method and that I should return to the clinic for an immediate evaluation should I experience any of those signs. I have been told how to get care in case of an emergency.

I have been given information on how to properly use the contraceptive method. I understand that in order for the contraceptive method to be effective, I must use it consistently and correctly.

I understand that it is my choice whether or not to use a contraceptive method and that I may stop using the method at any time. I have been told that I should use another method of birth control for ten days during the first usage of the contraceptive method in order to avoid becoming pregnant.

I have also been informed that my period will most likely return to its previous status when I stop taking the Pill or the Nuva-Ring. I understand that with Depo-Provera, my menstrual cycle may continue to be irregular for the next 7-12 months before returning to its normal status.

I understand that confidentiality will be maintained. I understand that a medical provider or a health educator is available to answer any questions I may have.

I have read all of the above information and hereby request Cal State San Marcos Student Health Services to provide appropriate evaluation and treatment (birth control drug or device). I have had all my questions regarding this and other available methods answered to my satisfaction.

Signed: _____ Student I.D. # _____

Printed Name: _____ Date: ____/____/____ DOB: _____

Office Use Only- Hormonal Contraceptive Method of Use:

Oral Contraceptive Date: ____/____/____ Nuva Ring Date: ____/____/____

Depo-Provera (DMPA) Date: ____/____/____

Medical Provider Signature: _____