PROOF OF PREGNANCY (P.O.P.)

Always call to verify office hours and cost.

The School Age Parent Program (SAPP) requires a proof of pregnancy from 1) a doctor or physician's assistant 2) a clinic/center that provides a document signed by a nurse or nurse practitioner.

Doctor's office Call your family doctor. Ask how much an examination and pregnancy test costs and/or make an appointment.

Denton County Health Department and Womens Health Care
190 N Valley Pkwy, Ste 203
Lewisville
972-434-4700
An appointment is not required. Office hours: M-Th 7am-6pm & Fri 8am-5pm
COST: $5

LifeTalk Resource Center
8380 Warren Pkwy, Suite 204
Frisco
214-618-9352
Call for office hours. Saturdays by appointment only. COST: Free

Mi Doctor
701 S. Stemmons Fwy
Lewisville
972-316-6495
You will need a Referral Form, available from any SAPP staff. COST: $15 with form.

MOMS Program
Baylor of Carrollton
4343 N Josey Lane
Carrollton
972-512-7359
Pregnancy testing and referrals. Medicaid help available if using these hospitals.
No appointment needed. (M & W 8:30-3:45) COST: Free.

Planned Parenthood
1356 W. Main Ste 1352
Lewisville
972-221-7644
A health care clinic that gives a medical exam for pregnancy, including a urine test. The exams are done by a female registered nurse practitioner.
No appointment necessary. COST: $34 for new patients/$30 for existing

Woman to Woman Pregnancy Resource Center
521 N. Locust
Denton
940-383-4494
Appointments preferred. Open M-F. Call for office hours. COST: Free

NOTE: The School Age Parent Program RN/Childbirth Educators case manage all LISD pregnant students. *When you have a proof of pregnancy*, bring the doctor's (or clinic's) note to the person who gave you this sheet (nurse or counselor). **Ms. Iversen, SAPP RN/CBE or Ms. Breaux, SAPP RN/CBE** will be notified and will send a pass so you can meet with her within a few days.

REPORT OF PREGNANCY

NAME OF PATIENT: _____

Month Pregnancy Began _____ Month Diagnosed _____

Estimated Delivery Date _____

Recommendations/Comments:

_____

X_____ _____
Name (print) **Today's Date**

X_____
Signature of Examining Professional

TITLE

Physician Advanced Nurse Practitioner Registered Nurse Other Medical Professional
_____

Telephone No. _____

Office Address: _____

_____

CLINIC: Fax form to SAPP office **972-350-9349** **OR**

STUDENT: Return to person providing you this form.

Updated 9/2014