\*This information is for the use of the Local Health Department for program evaluation purposes only.\*

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency or Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Write “Self” if neither)*

**Email or Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who are you getting a naloxone rescue kit for (circle your answer)?**

Self Family Member Friend Employee Student

Patient Client Resident Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about the training (circle your answer)?**

Facebook Twitter Television Newspaper Community Organization

Family/Friend Health Care Provider Employer Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please initial by each statement and sign *BEFORE RECEIVING* training:**

\_\_\_\_\_\_ (If Applicable): I understand that I am participating in group training and that the Local Health Department cannot guarantee my anonymity and privacy during this training as I am permitted to freely share any information about myself. Any information given to the Local Health Department during this group training, however, is subject to the Notice of Privacy Practices for the Local Health Department. I understand that I should respect other’s privacy and not share any personal information I hear during the group training with others.

\_\_\_\_\_\_ I acknowledge that I have been given an opportunity to read the Notice of Privacy Practices for the Local Health Department and to have any questions answered before signing.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Signature Date**

|  |  |
| --- | --- |
| **FOR OFFICE USE ONLY** | **ID Number:** |

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please initial by each statement and sign *AFTER RECEIVING* training:**

\_\_\_\_\_\_ I affirm that I am a person at risk of experiencing an opioid-related overdose or that I am a family member, friend, or other individual or entity in a position to assist an individual who, there is reason to believe, is at risk of experiencing an opioid-related overdose.

\_\_\_\_\_\_ I affirm that I have received Naloxone Rescue Kit Training, covering how to recognize an opioid overdose and how to respond to and treat an overdose, including how to administer the naloxone rescue kit.

\_\_\_\_\_\_ I understand I must contact emergency services (911) immediately before or after administering naloxone.

\_\_\_\_\_\_ I affirm that I was provided drug addiction treatment information and referrals to drug treatment programs, including programs in the local area and programs that offer medication assisted treatment that includes a federal Food and Drug Administration approved long-acting, non-addictive medication for the treatment of opioid or alcohol dependence.

\_\_\_\_\_\_ I understand I cannot resell the naloxone rescue kit(s) provided to me by the Local Health Department.

\_\_\_\_\_\_ I agree to report a naloxone rescue kit’s use (after the emergency has passed) to Local Health Department for their records as I am able.

\_\_\_\_\_\_ I acknowledge that I have been given the opportunity to review Indiana Code 16-42-27, *Drugs: Overdose Intervention Drugs*, which outlines my responsibilities as a lay responder, before signing.

My signature below indicates agreement that all information provided above is true and accurate:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Signature Date**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Trainer Signature Date**

|  |  |  |
| --- | --- | --- |
| **FOR OFFICE USE ONLY** | **ID Number:** | |
| **Training Location:** | | **Date: / /** |
| **Trainer Name:** | | |
| **Kit Serial Number:** | **Expiration Date: / /** | |
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| **Kit Serial Number:** | **Expiration Date: / /** | |