Naloxone in Public Schools
ATTESTATION OF TRAINING FORM

Print information for person signing agreement:

Last Name: __________________________________ First Name: ______________________________

School Name: __________________________________ Phone Number: _________________________

School Address: _______________________________ City/Zip-Code: __________________________

The Department of Health will track and record all Naloxone distributed to SD public schools by
recording the lot number and expiration dates of each package.

The Department of Health will supply public schools with Naloxone, an opioid antagonist after successful
completion of a DOH training program or equivalent.

I agree that my organization will notify the Department of Health of any Naloxone administration in
accordance with federal grant guidance.

I agree individuals who may be responsible for administering Naloxone to a student or faculty have
successfully completed the DOH training program or equivalent and will abide by guidelines governing my
organization.

Signed: ______________________________________________________________________________

Date: ________________________________________________________________________________

Witness: _____________________________________________________________________________

Date: ________________________________________________________________________________

08-12-2022