



## 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: \_\_\_\_\_