HAMILTON COUNTY COPE/QRT

[redacted]

Patient Name:_____

Please initial by each statement and sign AFTER RECEIVING training:

_____ I affirm that I am a person at risk or 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 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 QRT.

_____ I agree to report a Naloxone rescue kit's use on the provided postcard (after the emergency has passed) to QRT 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**

_____ _____

QRT Member **Date**

FOR OFFICE USE ONLY	KIT #
Training Location:	Date:
QRT Member Name:	Signature:
Kit Serial Number:	Expiration Date: