

**APPLICATION FOR AGENCY  
NALOXONE NASAL SPRAY PROGRAM****Facility:** *(Complete an application for each individual school)*

---

*(Name of Organization/Agency)*

---

Physical Address *(No PO. Boxes)*

---

*(City, State, Zip Code)*

---

Mailing Address *(if different from above)*

---

*(City, State, Zip Code)*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Qualified Supervisor of Health Officer or Administrator**

---

*(Name)*

---

*Title*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Naloxone Nasal Spray**Type of Agency: ☐ Police ☐ Recreation Space ☐ Other (Specify \_\_\_\_\_)

<b>Amount of Naloxone Nasal Sprays Requested</b>	<b>Quantity Requested</b>
Naloxone (Narcan ®) spray – 4 mg/0.1 ml nasal spray	
Naloxone (Kloxxado ™) spray – 8 mg/0.1 ml nasal spray	

Signature of Qualified Supervisor of Health/Administrator:

---

*Print Name***EMS Agency Use Only:****1. Application Received by:** \_\_\_\_\_ **Date:** \_\_\_\_\_**2. Application Complete:** \_\_\_\_\_**3. Reviewed by EMS:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Initials:** \_\_\_\_\_**4. Naloxone Issued: # Narcan:** \_\_\_\_\_ **# Kloxxado:** \_\_\_\_\_ **Issue Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

---

*Signature*

---

*Date*