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 _____)

Amount of Naloxone Nasal Sprays Requested	**Quantity Requested**
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*