☐ Consumer
☐ Professional Staff
☐ Community Member
☐ Family Member/Personal Contact

Region 10 Naloxone Registration Form

Location: _____ **Trainer:** _____ **Date:** _____
Site/Agency

Name: _____ **Participant#:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Date of Birth: _____ **Age:** _____ **Race:** _____

Gender Identity: Male ☐ Female ☐ Prefer not to say ☐ Prefer to self-describe _____

Do you identify as transgender? Yes ☐ No ☐ Prefer not to say ☐

Are you using any opiates? If so, which one(s)?

Heroin Methadone Other Opiates _____ N/A ☐

If you have ever used opiates, what age did you first use? _____ N/A ☐

In the past six months, have you used any of the following drugs regularly (more than 1-2 times per month)?

Cocaine	YES	NO	Valium/Xanax/Ativan/Klonopin	YES	NO
Alcohol	YES	NO	Speed (including Crystal)	YES	NO
Clonidine	YES	NO	PCP	YES	NO

# of times you have OD'd? _____

# of times you have witnessed an OD? _____
# of times 911 was called? _____ **# of people went to hospital?** _____ **# who died?** _____

Do you know or come in contact with someone who may be at risk for overdose? YES NO

Approved Prevention Educator: _____ Date: _____