Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

ILLINOIS STATE BOARD OF EDUCATION
Special Education Services Division
100 West Randolph, Suite 4-800
Chicago, Illinois 60601

UNDESIGNATED OPIOID ANTAGONIST REPORTING FORM

Directions: This form must be completed within three (3) calendar days after the administration of any undesignated opioid antagonist drug. All completed forms must be e-mailed to opioid@isbe.net.

DISTRICT NAME AND NUMBER	NAME OF SCHOOL
ADDRESS (Street, City, State, Zip Code)	CONTACT PERSON COMPLETING FORM
TELEPHONE (Include Area Code)	CONTACT E-MAIL
DATE OF INCIDENT	TIME OF INCIDENT _____ a.m. _____ p.m.

1. Age of individual receiving opioid antagonist: _____
2. Description of person receiving opioid antagonist: ***(Check one only)***
   - ☐ a. Student
   - ☐ b. Staff member
   - ☐ c. Visitor
   - ☐ d. Other (please specify) _____
3. Location of where symptoms developed: ***(Check one only)***
   - ☐ a. Within school building
   - ☐ b. On school grounds
   - ☐ c. Other (e.g., school activity location, field trip location, etc.) _____
4. Number of doses administered: _____
5. Type of person administering the opioid antagonist: ***(Check one only)***
   - ☐ a. Registered Nurse
   - ☐ b. Trained Personnel
   - ☐ c. Student
   - ☐ d. Other (please specify) _____

Comments (do not go beyond space provided):

Print Reset Form