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

100 North First Street
Springfield, Illinois 62777-0001

UNDESIGNATED OPIOID REPORTING FORM

WELLNESS DEPARTMENT

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 submitted via online collection portal webpage.

DISTRICT NAME AND NUMBER	RCDT CODE [Click Here to Find Code]	NAME OF SCHOOL

ADDRESS (Street, City, State, ZIP Code)	CONTACT PERSON COMPLETING FORM
TELEPHONE (Include Area Code)	CONTACT EMAIL
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 ***(Please contain your response into the space provided)***:

Print Reset Form