



## NARCAN ADMINISTRATION REPORT

**Complete this form within 24 hours of use!**

### INSTRUCTIONS:

At least annually, a school district shall report to the Michigan Department of Education all instances of administration of an opioid antagonist to a pupil at school. In order to report accurately you must complete this form, scan and email it to those listed below. Keep a copy at your building.

- HR Leave Specialist
- Joshua Flagg (Student Data Technician / Central Office)
- Mary Larsen RN or Leslie Wirth RN (District Nurse Assigned to your building)
- Your building leadership

*You must also complete and email an Incident Report since 911 was called. [FPS Incident Report](#)*

### INCIDENT DETAILS:

Date of Narcan Administration:		School/Building:	
Name of Person Administering Narcan			
Job Title of Person Administering Narcan			
Time EMS was contacted:	Was the person transported to hospital? <input type="checkbox"/> Yes -or- <input type="checkbox"/> No	How was the Narcan disposed of?	Incident Report completed and sent to required people: <input type="checkbox"/> Yes -or- <input type="checkbox"/> No
1st dose of Narcan Administered: <input type="checkbox"/> Stock Narcan 4mg Location: <input type="checkbox"/> Right nostril -or- <input type="checkbox"/> Left nostril Time administered: _____		Did symptoms improve with the 1st dose of Narcan? <input type="checkbox"/> Yes (Time taken to resolve: _____) -or- <input type="checkbox"/> No  Was a second dose needed (2-3 minutes after the first dose)? <input type="checkbox"/> Yes -or- <input type="checkbox"/> No	
2nd dose of Narcan Administered: <input type="checkbox"/> Stock Narcan 4mg Location: <input type="checkbox"/> Right nostril -or- <input type="checkbox"/> Left nostril Time administered: _____		Did symptoms improve with Narcan? <input type="checkbox"/> Yes (Time taken to resolve: _____) -or- <input type="checkbox"/> No	

### INFORMATION ABOUT THE PERSON WITH POTENTIAL/KNOWN OVERDOSE:

Select one: <input type="checkbox"/> Student <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Other	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Age: _____
Do you know what drug was used/overused? <input type="checkbox"/> Yes -or- <input type="checkbox"/> No If <b>yes</b> , which drug was it? <input type="checkbox"/> Fentanyl <input type="checkbox"/> Heroin <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Tramadol <input type="checkbox"/> Other: _____		
Presenting symptoms of (anaphylaxis/severe reaction): <input type="checkbox"/> Unresponsiveness/ unusual sleepiness <input type="checkbox"/> Constricted pupils <input type="checkbox"/> Cold/ clammy skin <input type="checkbox"/> Slow/ absent breathing <input type="checkbox"/> Slow/ absent heart rate <input type="checkbox"/> Blue nails/ lips <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Other: _____		