



Geauga Public Health

Project Dawn

Registration Refill

PLEASE PRINT

How did you hear about this training? (Please circle/fill in blank)

- A. Website
B. Social Media: Facebook/Twitter
C. Flyer: Location _____
D. Other: _____

Community Individual:

Last Name: _____ First Name: _____

Date of Birth: _____

Address: _____

City/Township: _____ State: _____ Zip: _____

Phone: _____ E-mail (optional): _____

Your signature below indicates that you have watched the ODH Project Dawn training video and you will dispense Narcan® (4mg/0.1 mL) intranasal spray according to the recommended training guidelines. When you administer Narcan®, always call 911.

Signature: _____ Date: _____