Georgia Prescription Drug Abuse Prevention Initiative
Safe Storage Program Participant Form

Name:_____

Organization:_____

Address:_____

_____

Phone:_____ Email:_____

How will this medicine safe be used?

- Store my medicines
- Store medicines for a child/relative
- Store medicines for patients/clients
- Store valuable items
- Other_____

Age:_____years ___prefer not to answer Sex: M/F ___prefer not to answer

Race/Ethnicity: Please mark all that apply

- Asian
- White/Caucasian
- Black/African American
- Native American
- Native Hawaiian/Pacific Islander
- Hispanic or Latino
- Prefer not to answer
- Other_____

Would you like to receive more information about prescription drug abuse prevention, intervention, treatment, and/or opioid response? Y or N

Would you like to get involved in prescription drug abuse prevention, education or advocacy? Y or N

D·B·H·D·D