AED Reporting Form

Submit this form to Superintendent/designee within forty-eight (48) hours of AED treatment.

EMERGENCY RESPONDER: _____

LOCATION OF AED USE: _____

PATIENT NAME: _____ **DATE OF INCIDENT:** _____

☐ Staff Member ☐ Student ☐ Parent/Visitor

Condition of patient upon arrival (check all that apply)

☐ unconscious

☐ not breathing

☐ no pulse and/or shows signs of circulation such as normal breathing, coughing or movement

NUMBER OF DEFIBRILLATIONS: _____

Please describe the incident from the beginning of the emergency until its conclusion:

_____

_____

_____

_____

_____

Were efforts terminated? ☐ Yes ☐ No If yes, please explain why the efforts were terminated.

_____

_____

_____ _____

Signature of Emergency Responder *Date*