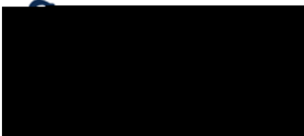

3412F-1

AED POST EVENT REPORT FORM

Location of event: ____

Date of event: ____________________ Time of event: ____________________ Non

____

Name of trained responder(s): ____

Was 911 called? Yes No If yes, name of 911 caller: ______________________________

Was pulse taken at initial assessment? Yes No

Was CPR given before the AED arrived? Yes No

If yes, name(s) of CPR responder(s): ____

____

Were shocks given? Yes No Total number of shocks: __________

Did victim: Regain a pulse? Yes No

Resume breathing? Yes No

Regain consciousness? Yes No

Was the procedure for transferring patient care to the local EMS agency executed? Yes No

If no, please explain: ____

____

Were any problems encountered? Yes No If yes, please explain: ______________________

____

Name of person completing form: ____

Other Responders: ____

Copy to: Director of School Safety
Risk Manager
Building AED Coordinator