

**Bellingham School District No. 501
1306 Dupont Street
Bellingham WA 98225**

4262F1

AED POST EVENT REPORT FORM

Location of event: _____

Date of event: _____ Time of event: _____

Automated External Defibrillator oversight physician: _____

District AED Coordinator: _____

Victim's initials: _____

Was the event Witnessed or non-witnessed? Witnessed _____ Non-witnessed _____

Name of trained responder(s): _____

Internal response plan activated? Yes _____ No _____

Was 9-1-1 called? Yes _____ No _____ If yes, name of 9-1-1 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: _____

Any problems encountered? _____

Name of person completing form: _____

Form Reviewed By:

- District AED Coordinator
- Nurse
- Risk Manager
- Building AED Coordinator

Other Responders:

- _____
- _____
- _____
- _____