

AED POST EVENT REPORT FORM

Location of event: _____

Date of event: _____ Time of event: _____

Automated External Defibrillator oversight physician: _____

Building AED Coordinator: _____

Victim's initials: _____ Was the event: Witnessed Non-witnessed

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