DESIGNATED AUTOMATED EXTERNAL DEFIBRILLATOR (AED) USERS

Compliance with AED Requirements

NOTE: This form must be completed and submitted to the lead school nurse within 48 hours of the incident.

Emergency responder: _____

Location of AED use: _____

Patient name: _____
___ staff member ___ student ___ parent/visitor

Address: _____

_____

Age: _____ Gender: Male _____ Female _____ Date of incident: _____

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

Bystander CPR : yes ___ no ___ Cardiac arrest after arrival: yes ___ no ___

Number of defibrillations: _____

Efforts terminated at incident site? yes ___ no ___ If yes, please explain why efforts were terminated. _____

_____

_____

Any complications? yes ___ no ___

Comments: _____

_____

_____

_____

_____

Signature of emergency responder _____Date _____