Board Policy 8310F(3): Automated External Defibrillator (AED) Incident Report

Date of Incident: _____ Time of Incident: _____

Location of Incident (which building, where in building, etc.):

_____

Patient's Age: _____ Patient's Sex: ☐ Male ☐ Female

CPR prior to defibrillation: ☐ Attempted ☐ Not Attempted

Cardiac Arrest: ☐ Not Witnessed ☐ Witnessed by Bystander
☐ Witnessed by AED team member

Estimated time (in minutes) from arrest to CPR: _____

Shock: ☐ Indicated ☐ Not Indicated

Estimated time (in minutes) from arrest to 1st AED shock: _____

Number of shocks: _____

Additional Comments:

_____

Patient Outcome at Incident Site:

☐ Return of pulse and breathing
☐ Return of pulse with no breathing
☐ Return of pulse, then loss of pulse
☐ No return of pulse or breathing
☐ Became responsive
☐ Remained unresponsive

Name of AED Operator (Transporting Ambulance):

_____

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Name of Facility Patient was Transported To:

Name of Emergency Health Care Provider:

Signature of Health Care Provider

Date of Report

This report is to be completed by the Emergency Health Care Provider or AED User within 5 business days of use of an AED.

The completed report must be mailed/returned to the School District office.