

KING GEORGE COUNTY SCHOOLS
USE OF AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

This form must be completed and given to a school administrator anytime the AED is removed from the cabinet for possible use. The form must be completed as soon as possible after the event.

Complete both sides if the AED is used.

School: _____ **Date:** _____ **Time:** _____

Circumstances of Removal of AED from cabinet: _____

Was AED used: Yes _____ No _____

Organization using AED: _____

Organization's Contact Name: _____

Contact Phone Number: _____

Notify School Nurse and Principal if the AED is removed from the cabinet.

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AUTOMATED EXTERNAL DEFIBRILLATION (AED)
INCIDENT REPORT

Date of Incident ___/___/___ Time of Incident ___:___ AM/PM

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

Patients Name: _____

Patients Address: _____

Patients Age: _____ Patients Sex: _____ Male _____ Female

CPR prior to defibrillation: Attempted _____ Not Attempted _____

Cardiac Arrest: Not witnessed _____ Witnessed by bystander _____
Witnessed by AED person _____

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: (what was patient doing before, and medical condition, etc.)

Patient Outcome at incident site:

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

Name of AED operator: _____

Transporting ambulance: _____

Name of facility patient was transported to: _____

**This report is to be completed by AED operator
within 24 hours of use (weekdays) of an AED.**