El Paso Independent School District

El Paso Independent School District
Health Services Department
Public Access Defibrillation Program
AED Use Reporting Form

The following form must be completed on all uses of the AED:

Campus: _____ Date: _____

Client Information:

Name: _____ Age: _____

Address: _____

_____ Gender: ☐Male ☐Female

Site of Incident: _____

☐YES ☐NO Witnessed Arrest Name: _____

☐YES ☐NO Bystander CPR initiated Name: _____

☐YES ☐NO Breathing upon arrival of designated responders

☐YES ☐NO Pulse upon arrival of designated responders

☐YES ☐NO Cardiac Arrest after Arrival

Number of Defibrillations Administered _____

☐YES ☐NO Transport to Hospital By Whom: _____

☐YES ☐NO Any Complications

☐YES ☐NO Efforts terminated in the Field

Name of AED Rescuer(s) _____

_____

Name of 9-1-1 Caller _____

COMMENTS: _____

_____

_____

_____

_____ _____

User's Name **User's Signature**