**ALLOWAY TOWNSHIP SCHOOL DISTRICT**
**Alloway, New Jersey**

**Exhibit**

**FILE CODE: 5141**
**__X__ Monitored**
**__X__ Mandated**
**__X__ Other Reasons**

AUTOMATED EXTERNAL DEFIBRILLATOR (AED) INCIDENT REPORT

Please complete all of the information to the best of your ability and forward it to the school nurse. The school physician will review the information.

School: _____ Location: _____

Name of Victim: _____ Age of Victim: _____

Date of Incident: _____ Time of Incident: _____

Victim's Known Medical History:

_____

_____

_____

Check One:

- ☐ Student
- ☐ Board of Education Employee
- ☐ Other

Circumstances of how victim was found:

_____

_____

_____

Who called "911":

_____

Who used AED and how many shocks were delivered:

_____

Time victim was placed in the care of Emergency Medical Services:

_____

Victim transported to which hospital:

_____

Family notified: _____ Yes _____ No If so, by whom: _____

Other information:

_____

_____

Signature of AED User: _____

Name (please print): _____