EVIDENCE OF CPR AND AED TRAINING

School/Site Name: _____

Date of Plan: _____ Date Submitted: _____
(No later than September 1st)

Number of AED's: _____

Location of AED:

During School Hours: _____

After School Hours: _____

Responsible Person: _____

CPR/AED Team Member (First and Last Name)	CPR/AED Expiration Date (Month and Year)	Training Organization (i.e., Red Cross, AHA)

Method of Activating Team: (example: over the loud speaker "Mr. Smith, go to room #2")

_____

_____

_____

Person Responsible for Maintenance of AED: _____

This form shall be sent to the Office of District and School Security.

4/05
8/05
10/05
3/06