



LIFESAVING SOCIETY
The Lifeguarding Experts

Airway Management

(Revised 2022)

Side 1: Please record each candidate's name and contact information accurately.

Date of birth	Prerequisite	Knowledge	Barrier devices	Oral airways	Oxygen delivery system	Oxygen supplementation	Manual suction	Bag-valve-mask	Result
		1	2	3	4	5	6	7	
1 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
2 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
3 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
4 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
5 Name Address Apt # City Postal Code E-mail Phone Year Month Day									

☐

Check box if there are more candidates on the reverse side of this page.

This test sheet is Page _____ of _____ Pages.



Satisfactory Performance



- Fail

Total Pass
for Exam

Total Fail
for Exam

Payment information

☐

Exam fees attached

☐

Exam fees not attached

Send invoice or receipt to:

Host name (Affiliate)

()

Telephone

Street address

City

Prov.

Postal code

Exam information

Exam date: YY MM DD

Facility name (e.g., name of pool)

Telephone

First Aid Instructor who holds Airway Management

Instructor's name

ID#

E-mail address

()

Telephone

Signature required

This section to be completed by the First Aid Examiner who holds Airway Management and who evaluated the candidates.

Name

ID# (optional)

E-mail address

()

Telephone

Signature required



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Airway Management

(Revised 2022)

Side 2: Please record each candidate's name and contact information accurately.

Date of birth	Prerequisite	Knowledge	Barrier devices	Oral airways	Oxygen delivery system	Oxygen supplementation	Manual suction	Bag-valve-mask	Result
		1	2	3	4	5	6	7	
6 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
7 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
8 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
9 Name Address Apt # City Postal Code E-mail Phone Year Month Day									
10 Name Address Apt # City Postal Code E-mail Phone Year Month Day									

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Check box if there are more candidates on the reverse side of this page.

This test sheet is Page _____ of _____ Pages.



Satisfactory Performance



Fail

Total Pass
for Exam

Total Fail
for Exam

Host name (Affiliate)

()

Telephone

Please complete Instructor and Payment information sections on Side 1 of the test sheet. Host name, Exam information and Examiner sections must be completed on both sides 1 and 2 of the test sheet.

Exam information

Exam date: YY MM DD

Facility name (e.g., name of pool)

()

Telephone

This section to be completed by the First Aid Examiner who holds Airway Management and who evaluated the candidates.

Name

ID# (optional)

E-mail address

()

Telephone

Signature required