LIFESAVING SOCIETY
The Lifeguarding Experts

Airway Management

(Revised 2024)

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

	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

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

2

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

3

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

4

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

☐ **Check box if there are more candidates on the reverse side of this page.**
This test sheet is page _____ of _____ page(s).

✔ – Satisfactory Performance
X – Fail

Total Pass for Exam ☐ **Total Fail for Exam** ☐

Please complete all sections below

Payment information ☐ Exam fees attached ☐ Exam fees not attached

Host name (Affiliate or Organization paying the exam fees) ( ) Telephone

Street address

City Prov. Postal Code

First Aid Instructor who holds Airway Management

Instructor's name ID#

E-mail address

( ) Telephone Signature

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.

Examiner's name ID# (optional)

E-mail address

( ) Telephone Signature

Return completed test sheet to the Lifesaving Society Branch Office promptly after the exam. ***Retain one copy for your records.*** *Do not send cash by mail.*

LIFESAVING SOCIETY
The Lifeguarding Experts

Airway Management

(Revised 2024)

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

	Knowledge	Barrier devices	Oral airways	Oxygen delivery system	Oxygen supplementation	Manual suction	Bag-valve-mask	Result
	1	2	3	4	5	6	7	
5								

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

6

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

7

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

8

Name

D.O.B. (YY/MM/DD) Phone

Address Province

City Postal Code

Email

Prerequisites checked: ☐

Standard First Aid Date Earned: _____ Location: _____

☐ **Check box if there are more candidates on the reverse side of this page.**
This test sheet is page _____ of _____ page(s).

✔ – Satisfactory Performance
X – Fail

Total Pass for Exam ☐ **Total Fail for Exam** ☐

Please complete all sections on Side 1 of test sheet. Host, exam information *and* examiner sections *must be completed on both sides 1 and 2 of the sheet.*

Host name (Affiliate or Organization paying the exam fees)

( )
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.

Examiner's name ID# (optional)

E-mail address

( )
Telephone Signature

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