

MONTHLY CRASH CART/EMERGENCY EQUIPMENT CHECKS

CLINIC _____ YEAR _____

January	February	March
Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Me (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____
April	May	June
Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____
July	August	September
Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____
October	November	December
Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____	Date _____ Place <input type="checkbox"/> in box Laryngoscope handles/blades <input type="checkbox"/> Blood Pressure Cuff <input type="checkbox"/> IV Supplies/Meds (no expirations) <input type="checkbox"/> Ambubags <input type="checkbox"/> AED (turn on to check battery) <input type="checkbox"/> Suction Unit <input type="checkbox"/> O ₂ tank (full) <input type="checkbox"/> O ₂ gauge <input type="checkbox"/> Signature _____