Mississippi Department of Youth Services
Division of Youth Services

Medical Equipment Check Sheet

Year: _____

Equipment Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials

Checks are to be completed within the first week of every month. Initial and date each box as you complete your checks. If problems are noted place an asterisk (*) in that box and explain problem on the back of the form. Notify the Health Services Supervisor of any problems noted.

Date	Time	Problem:	Reported to:	Signature