

**Mississippi Department of Human Services
Division of Youth Services
Medical Services**

FIRST AID and/or SPILL KIT USAGE FORM

First Aid Kit

To be completed by person opening the Kit (Please complete below)

- First Aid Kit Number: _____
- First Aid Kit Location: _____
- Item(s) used:
 TAPE KLING/COBAN WRAP 4X4'S GLOVES CPR SHIELD

Explain reason for use: _____

Employee Signature: _____ **Date:** _____

Spill Kit:

To be completed by person opening the Kit (Please complete below)

- Spill Kit Location: _____

Explain reason for use: _____

Employee Signature: _____ **Date:** _____

To be completed by the Nurse

- Item(s) replaced:
 TAPE KLING/COBAN WRAP 4X4'S GLOVES CPR SHIELD SPILL KIT

Comment: _____

Nurse Signature: _____ **Date:** _____