

NURSES WEEKLY CHECKLIST REVIEW

DAILY OXYGEN CHECKLIST

Student Name _____

Inspect applicable equipment/supplies below daily. Check off each appropriate item as inspected. Enter any applicable remarks and initial. If student is absent, write "Absent" in Comments column on appropriate day. The person administering care is responsible for care of equipment and shall perform inspection as stated above.

HEALTH CARE ASSISTANT SIGNATURE

DATE	SIGNATURE	INITIAL

DATE	SIGNATURE

Month/Year (mm/yy):	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
Date (dd):																				
Oxygen (____ liters per minute)																				
Oxygen Tank/Container (____ % full)																				
Tubing																				
Nasal cannula/Mask/Trach collar																				
Regulator (gauge) with wrench																				
Humidifer & distilled water (if ordered)																				
Initials																				

Comments:

Month/Year (mm/yy):	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
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