

CHILDREN'S SERVICES ASSESSMENT FORM CSAF-003

First Aid Kit Checklist – Travel Kits

To be completed using Children's Services Safety Guidance Procedure No. 08/07 (First Aid)

First Aid Kit Checklist

| | |
|--|--|
| Location of First Aid Kit/Box | |
| Vehicle & Registration No. <i>(if applicable)</i> | |
| Identity No. of First Aid Kit/Box <i>(if applicable)</i> | |
| Date of Initial First Aid Kit/Box Check | |
| Name of Assessing First Aider | |

Contents Check

| No. | Travelling First Aid Box | Minimum Required | Actual Quantity | Quantity Required |
|-----|--|------------------|-----------------|-------------------|
| 1 | Guidance card | 1 | | |
| 2 | Individually wrapped sterile adhesive dressings (assorted sizes) | 8 | | |
| 3 | Individually wrapped triangular bandages (preferably sterile) | 2 | | |
| 4 | Large individually wrapped sterile unmedicated wound dressings | 1 | | |
| 5 | Medium individually wrapped sterile unmedicated wound dressings | 2 | | |
| 6 | Safety pins | 2 | | |
| 7 | Individually wrapped cleansing wipes | 4 | | |
| 8 | Pair of disposable gloves | 2 | | |
| 9 | Sterile eye pads | 2 | | |
| 10 | Airway reviver | 1 | | |
| 11 | N/Saline 300ml | 2 | | |
| 12 | Space blanket | 1 | | |
| 13 | Gauze swabs | 1 | | |
| 14 | Vomit bags | 6 | | |
| 15 | Clinical waste bag | 1 | | |
| 16 | Cold compress | 2 | | |
| 17 | Crepe Bandages | 1 | | |
| 18 | Tape | 1 | | |
| 19 | Tissues | | | |
| 20 | Sanitary equipments (pads and tampax) | | | |

Additional Checks

| | | | |
|---|--|-----|----|
| 1 | Are all items of first aid within expiry date? | YES | NO |
| 2 | Are all items of first aid in good, undamaged condition? | YES | NO |
| 3 | Is the first aid kit/box in good condition & undamaged? | YES | NO |
| 4 | Is the location of the first aid kit/box clean and accessible? | YES | NO |
| 5 | Is the first aid location sign present & in good condition? | YES | NO |
| 6 | Is the list/sign of trained first aiders present & up-to-date? | YES | NO |

Summary of Actions

| | | |
|---|-----|----|
| FIRST AID KIT PASSED (eg. 3-MONTH) CHECK & NO ACTION REQUIRED | YES | NO |
|---|-----|----|

Actions required if 'NO'

| | | | | | |
|------------------|--|-----------------------|--|---------------|--|
| Name of Assessor | | Signature of Assessor | | Assessed Date | |
|------------------|--|-----------------------|--|---------------|--|

Follow-up Actions

| | | |
|--|-----|----|
| REQUIRED ACTIONS IMPLEMENTED/SHORTAGES REPLENISHED | YES | NO |
|--|-----|----|

| | | | | | |
|------|--|-----------|--|------|--|
| Name | | Signature | | Date | |
|------|--|-----------|--|------|--|