# MEDICATION BOX INVENTORY CONTROL SHEET: BLS

Date: ______  Unit Number: _____  Med Box #: ________

EMS Provider Signature: ________________________________

EMS Provider Print Name: ________________________________

**FULL INVENTORY ON THE LAST SUNDAY OF EACH MONTH**

- [ ] Full Inventory  Old Seal: ______  New Seal: ________
- [ ] Box Left Sealed  Current Seal: ________

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>AMOUNT</th>
<th>QUANTITY</th>
<th>EXPIRATION DATES (Earliest)</th>
<th>ACCOUNTED FOR</th>
<th>DISCREPANCY FOUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol (Proventil)</td>
<td>2 x (2.5mg)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Aspirin</td>
<td>1 Bottle (min 8)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Naloxone</td>
<td>1 x (2mg)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nitroglycerine</td>
<td>1 Bottle (min 8)</td>
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<tr>
<td>Ondansetron (Zofran) ODT</td>
<td>2 x (4mg)</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment</th>
<th>AMOUNT</th>
<th>QUANTITY</th>
<th>EXPIRATION DATES (list each)</th>
<th>ACCOUNTED FOR</th>
<th>DISCREPANCY FOUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucosal Atomization Device</td>
<td>2 each</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(MAD)</td>
<td></td>
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<tr>
<td>Medication Cups</td>
<td>5 each</td>
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</tbody>
</table>

- [ ] Med Box Understocked

Med Box Expires:

Due To:

- Nitro: [ ] Unopened  [ ] Opened: ______
- Aspirin: [ ] Unopened  [ ] Opened: ______
MEDICATION DISCREPANCIES ONLY: (Attach additional pages if necessary)

The EMS Provider who discovers the discrepancy shall complete questions 1-3. The immediate supervisor (volunteer or career) shall investigate and complete question 4.

1) Discrepancy Found:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

2) Possible Causes or Deemed Related to Incident#.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3) Reported to Whom: (Include date and time)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4) Follow-Up Actions:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Copy the entire form and forward to EMS Operations within 24-hours of the occurrence.