HEALTH AND MEDICATION RECORD **GROUP: _____ NAME: _____**

Age _____ Sex _____ **R = Refused** **M = Missed** **Session Dates:**

MEDICATION	DOSE (MG)	AMOUNT (# OF TAB or ML)	TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1.)								
			LUNCH (11:30 AM)					
			AFTERNOON (2PM)					
# Pills/Tabs Packed @ Home ( )			OTHER					
RN/LPN Confirm Count ( )								
2.)								
			LUNCH (11:30 AM)					
			AFTERNOON (2PM)					
# Pills/Tabs Packed @ Home ( )			OTHER					
RN/LPN Confirm Count ( )								
3.)								
			LUNCH (11:30 AM)					
			AFTERNOON (2PM)					
# Pills/Tabs Packed @ Home ( )			OTHER					
RN/LPN Confirm Count ( )								
4.)								
			LUNCH (11:30 AM)					
			AFTERNOON (2PM)					
# Pills/Tabs Packed @ Home ( )			OTHER					
RN/LPN Confirm Count ( )								

PLEASE CHECK IF MEDS GIVEN BY: ☐ mouth ☐ with water ☐ crushed ☐ w/applesauce or pudding

ALLERGIES _____ _____ _____ **SIGNATURE** _____

Treatment/Home Device	APPLICATION	TIME	ADDITIONAL NOTES

HEALTH AND MEDICATION RECORD **GROUP: _____ NAME: _____**

TO BE COMPLETED BY MEDICAL STAFF ONLY		
INITIAL ASSESSMENT:	NO S/S ILLNESS/INJURY ☐	NO MEDICAL ASSISTANCE NEEDED ☐

DATE	TIME	TREATMENT	DAY	DAY	DAY	DAY	DAY

DATE	TIME	REASON FOR VISIT/ASSESSMENT	TREATMENT	PROVIDER'S INITIALS

NURSE'S NAME	SIGNATURE w/Credential	INITIALS