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

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

MEDICATION	DOSE (MG)	AMOUNT (# OF TAB or ML)	TIME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY
1.)			BREAKFAST (8AM)					
			LUNCH (1PM)					
			AFTERNOON (4PM)					
# Pills/Tabs Packed @ Home ( )			DINNER (6PM)					
RN/LPN Confirm Count ( )			BED (8PM)					
2.)			BREAKFAST (8AM)					
			LUNCH (1PM)					
			AFTERNOON (4PM)					
# Pills/Tabs Packed @ Home ( )			DINNER (6PM)					
RN/LPN Confirm Count ( )			BED (8PM)					
3.)			BREAKFAST (8AM)					
			LUNCH (1PM)					
			AFTERNOON (4PM)					
# Pills/Tabs Packed @ Home ( )			DINNER (6PM)					
RN/LPN Confirm Count ( )			BED (8PM)					
4.)			BREAKFAST (8AM)					
			LUNCH (1PM)					
			AFTERNOON (4PM)					
# Pills/Tabs Packed @ Home ( )			DINNER (6PM)					
RN/LPN Confirm Count ( )			BED (8PM)					

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 **CABIN: _____** **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