VITAL SIGNS MONITORING LOG

Month/Year: _____

RESIDENT NAME
DATE OF BIRTH
ROOM #

DATE / TIME	TEMP (F)	BP (MMHG)	PULSE (BPM)	RESP (RPM)	SPO2 (%)	WEIGHT	NOTES / OBSERVATIONS	STAFF

DATE / TIME	TEMP (F)	BP (MMHG)	PULSE (BPM)	RESP (RPM)	SPO2 (%)	WEIGHT	NOTES / OBSERVATIONS	STAFF

PHYSICIAN NOTIFICATION THRESHOLDS / SPECIAL INSTRUCTIONS
NURSE REVIEW SIGNATURE / DATE