ELDER CARE DAILY VITAL SIGNS

Month/Year: _____

Resident Name: _____
Date: _____
Room #: _____

TIME	TEMP (F/C)	BP (SYS/DIA)	PULSE (BPM)	O2 SAT (%)	BLOOD SUGAR	NOTES / OBSERVATIONS
AM:						
Noon:						
PM:						
Night:						

Daily Care Checklist:

[ ] Medication Taken [ ] Hydration (8+ glasses) [ ] Mobility/Exercise [ ] Hygiene/Bathing [ ] Bowel Movement

Caregiver Signature: _____ Emergency Contact: _____