

MASSACHUSETTS EMT-PARAMEDIC CLINICAL INTERNSHIP SKILL DOCUMENTATION

Student Name: _____ EMT# _____

IV BOLUS MEDICATION ADMINISTRATION
OEMS minimum requirement is five (5)

	Date	Age/Sex	IV Medication / Dosage / Route	Location	Preceptor Signature	Title
sample	03/07/04	27/ F	50% Dextrose - 25 grams - IVP	ED	<i>Paul Sugar, R.N.</i>	RN
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

IV INFUSION MEDICATION ADMINISTRATION
OEMS minimum requirement is five (5)

	Date	Age/Sex	Medication Mixture / Rate	Location	Preceptor Signature	Title
sample	07/22/04	37/ M	Lidocaine 4 mg/ml @ 2 mg/min	CCU	<i>Paul Sugar, R.N.</i>	RN
1.						
2.						
3.						
4.						
5.						
6.						
7.						
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I attest the information listed above is a true and accurate record to the best of my knowledge.

Signature of the Program Clinical Coordinator _____

Date _____

