



Urinary Catheterization Log

Student's Name: _____ School Year : _____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

Type of Tube: St. cath ___ Foley: ___ Catheter tube size: _____ Location: Urethra

Frequency: _____ Time of day: _____

Date	Time Started	Redness present	Time Finished	Urine Removed or amount	Tolerated w/o Incident	Initials	2nd Initials
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
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					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		



Urinary Catheterization Log

Student Name: _____ Date of Birth: _____

Date	Time Started	Time Finished	Urine Removed or amount removed	Tolerated w/o Incident	Initials	2nd Initials
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
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				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Staff Signature	Staff Initials	Date