**RRU Group Activity Health/Medical Incident Form**

**Program: Today’s date:**

**Date of medical incident:**

**Name of student: Time & place of incident (if applicable):**

**Description of injury or symptoms presented:**

**Description of care sought and provided (include prognosis, any medications administered or x-rays taken):**

**Medical provider (name, address & phone number of hospital/clinic; doctor’s name):**

**Follow up required (if applicable):**

**Report filed by: Signature:**

**Please note this form**

**will be forwarded to Student Service’s CARE Team**

**within 24 hours of completing**