

RRU Group Activity Health/Medical Incident Form

Program:	
Today's Date:	
Date of Medical Incident:	
Name of Person Requiring Medical Attention:	
Time and Place of Incident:	

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, including notifications to Emergency Contacts):

--

Report completed by:	
Signature:	