F004-MEDICAL LOG RECORD
THIS FORM MUST BE MAINTAINED BY THE HEALTH SUPERVISOR
(Required to be kept onsite)

PALOMAR
CHRISTIAN CONFERENCE CENTER

Please include the following information about the incident: Who, What, When, and Where.

Person Treated:_____ Date:_____ Time:_____

☐ Parent/Guardian notified Date & Time Notified:_____

Medication Dispensed:_____ Dosage:_____ Interval dispensed:_____

Person dispensing medication/administering First Aid:_____

First aid/medical treatment rendered and notes:_____

Health Supervisor's Stmt: You may opt out by checking the following statement: ☐ I decline to provide medical records to PCCC.

Group Name:_____ Health Supervisor:_____

Signature:_____ Date:_____