F004-MEDICAL LOG RECORD

THIS FORM MUST BE MAINTAINED BY THE HEALTH SUPERVISOR

(Required to be kept onsite)

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:_____

_____

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:_____

_____

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:_____

_____

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:_____

_____

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:_____