

Rock Lake United Church Camp
Medical Incident Report

Patient's Name: _____ Age: _____

Cabin Leader: _____ Adult Supervisor: _____

Date of Incident: _____ Time: _____ Location: _____

Full details of incident which caused accident/illness: _____

Full description of injury/illness: _____

If accident, name of the Leader in Charge: _____

Diagnosis: _____

Treatment: _____

Was Parent/Guardian notified? NO YES

If yes, date/time: _____ By whom: _____

IF OFF-SITE MEDICATION/ATTENTION WAS REQUIRED

Hospital/Clinic Attended: _____

Attending Doctor: _____

Was medical authorization form taken with patient? NO YES

Signature of Nurse/First Aid Attendant

Date

THIS REPORT IS TO BE SUBMITTED TO THE CAMP DIRECTOR