

EVENT MEDICAL LOG

Event Name: _____

Location: _____

First-Aider(s): _____

| | | | | | | | | | |
|------------|--|--|-------------|--|-------|--|-----------|----------|--------------------------------|
| 1 | Date: | | Time/Start: | | Name: | | Time/End: | | |
| | What Happened?: | | | | | | | | Girl <input type="checkbox"/> |
| | | | | | | | | | Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | |
| Treatment: | | | | | | | | | |
| | | | | | | | | Done by: | |
| 2 | Date: | | Time/Start: | | Name: | | Time/End: | | |
| | What Happened?: | | | | | | | | Girl <input type="checkbox"/> |
| | | | | | | | | | Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | |
| Treatment: | | | | | | | | | |
| | | | | | | | | Done by: | |
| 3 | Date: | | Time/Start: | | Name: | | Time/End: | | |
| | What Happened?: | | | | | | | | Girl <input type="checkbox"/> |
| | | | | | | | | | Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | |
| Treatment: | | | | | | | | | |
| | | | | | | | | Done by: | |
| 4 | Date: | | Time/Start: | | Name: | | Time/End: | | |
| | What Happened?: | | | | | | | | Girl <input type="checkbox"/> |
| | | | | | | | | | Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | |
| Treatment: | | | | | | | | | |
| | | | | | | | | Done by: | |

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|---|--|-------------|-------|-----------|---|
| 5 | Date: | Time/Start: | Name: | Time/End: | |
| | What Happened?: | | | | Girl <input type="checkbox"/> Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| | Treatment: | | | | Done by: |
| | | | | | |
| 6 | Date: | Time/Start: | Name: | Time/End: | |
| | What Happened?: | | | | Girl <input type="checkbox"/> Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| | Treatment: | | | | Done by: |
| | | | | | |
| 7 | Date: | Time/Start: | Name: | Time/End: | |
| | What Happened?: | | | | Girl <input type="checkbox"/> Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| | Treatment: | | | | Done by: |
| | | | | | |
| 8 | Date: | Time/Start: | Name: | Time/End: | |
| | What Happened?: | | | | Girl <input type="checkbox"/> Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| | Treatment: | | | | Done by: |
| | | | | | |
| 9 | Date: | Time/Start: | Name: | Time/End: | |
| | What Happened?: | | | | Girl <input type="checkbox"/> Adult <input type="checkbox"/> |
| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| | Treatment: | | | | Done by: |
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| | Verify and check box: <input type="checkbox"/> Over-the-Counter (OTC) & Provided Prescription <input type="checkbox"/> Health History Parent called <input type="checkbox"/> Y <input type="checkbox"/> N | | | |
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