

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.

A. FACILITY INFORMATION

Camp Name: _____ Facility Code: _____
 Camp Address _____ Date Reported ____/____/____

B. EVENT INFORMATION

eHIPS Incident Number: _____ (Note: eHIPS will assign when entered into system)

Type of Incident: Illness (single case) Illness Outbreak (multiple case)
 Date of Incident/Onset ____/____/____ Time of Occurrence/Onset ____ : ____ (Military time)

Note: For illness outbreak, utilize this form for the event information and initial victim, complete section C-2 and complete form DOH-61a.

C-1. VICTIM INFORMATION

Material in Shaded area is confidential

eHIPS Victim ID Number: _____ (Note: eHIPS will assign when entered into system)

Name of Victim (Last, First, MI): _____
 Home Address: _____
 Name of Parent or Guardian (Last, First, MI): _____ Home Phone Number: (____) _____ - _____

Note: All the above confidential information must be collected and maintained by LHD for appropriate investigation and follow-up.

Age: ____ **Sex:** Female Male **Status:** Camper Developmentally Disabled Camper CIT/Jr. Counselor Counselor Other Staff* Other* Specify _____

2. Victim Information- (Complete for illness outbreak and attach DOH61a)

Number of campers: male ____ female ____ **Number of staff:** male ____ female ____ **Number of others:** male ____ female ____

D. ILLNESS DESCRIPTION

- Report camper and staff communicable diseases, outbreaks and illness requiring resuscitation, admission to a hospital, or resulting in death.

1. Characterize the Illness _____

a. Acute illness or disease*	e. Cardiac	i. Gastrointestinal*	k. Neurological	z. Other*
b. Allergic reaction*	f. Chronic illness or disease*	j. Mandated reportable communicable disease* (Part 2 10NYCRR)	l. Parasitic*	* Specify _____
c. Anaphylactic shock*	g. Dental problem/infection	m. Respiratory infection	n. Seizure disorder	
d. Asthma attack	h. Eye infection			
2. Is illness communicable? Yes No If yes, indicate suspected means of transmission. _____

a. Airborne	b. Animal bite or contact	c. Foodborne	d. Insect bite	e. Spread by person to person contact	f. Waterborne	z. Other* *Specify _____
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E. TREATMENT

- For each person providing treatment, indicate the location and type of treatment that person provided in the table below. Up to FOUR treatment providers may be indicated. Specify all selections marked with an asterisk.

1. Who Provided Treatment?

a. Dentist	c. First Aider*	e. Nurse Practitioner	g. Physician's Assistant	i. Victim
b. Emergency Medical Technician	d. Licensed Practical Nurse	f. Physician	h. Registered Nurse	z. Other*
2. Where was treatment provided?

a. At Camp infirmary	b. Admitted to Hospital	c. At site	d. Dentist's Office	e. Doctor's Office	f. Emergency Clinic	g. Emergency Room	z. Other*
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3. What Treatment was provided? (Indicate as many as apply)

a. Antibiotic	d. Antiseptic	g. Epinephrine Administration	j. Resuscitation	l. Sutures,* Staples*, medical glue (indicate how many below)*	z. Other*
b. Antihistamine/Decongestant	e. Cast/Splint	h. Gastrointestinal (antacid, laxative)	k. Supportive (bedrest, observation, physical therapy)		
c. Anti-inflammatory/analgesic	f. Diagnostic	i. Psychotropics			

