MARYLAND YOUTH CAMP INCIDENT REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH, ext.8417 Fax 410-333-8926

A. PERSONAL INFORMATION

1. Name **(DO NOT INCLUDE NAME ON COPY SENT TO DHMH)**
2. Age
3. Gender ☐ Male ☐ Female
4. Check One ☐ Day Camper ☐ Residential Camper ☐ Camp Employee ☐ Other:

B. INCIDENT INFORMATION *Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.*

5. Report Type (*check one*) ☐ Injury ☐ Illness ☐ Medication Error ☐ Epinephrine
6. Date of Incident/Illness Onset
7. Time of Incident/Illness Onset ____:____ ☐ AM ☐ PM

8. Provide short description, do not include names: ☐ ***Additional information attached***

9. Did the incident require any of the following: AED: ☐ No ☐ Yes CPR: ☐ No ☐ Yes Epinephrine: ☐ No ☐ Yes Inhaler: ☐ No ☐ Yes

10. Was the person transported off-site for medical care?
☐ No ☐ Yes, complete A. and B.
A. Transported by:
☐ Camp vehicle ☐ Personal vehicle
☐ Ambulance ☐ Helicopter
B. Treated or evaluated at (*check all that apply, specify the name of facility*):
☐ Urgent Care ☐ Doctor's Office
☐ Hospital ☐ Other
(specify) _____

11. After off-site or on-site medical evaluation, the person (*check all that apply*):
☐ Was admitted to the hospital
☐ Went home. Date_____
☐ Returned to camp with medical restrictions
☐ Returned to camp with no restrictions

12. Did incident result in death?
☐ No
☐ Yes List Date of death: / /
List Time of death: ☐ am/☐ pm

13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?
☐ No ☐ Yes

14. Did the incident prompt a report or investigation by government authorities or officials?
☐ No
☐ Yes (*specify*)
Government Agency _____
Report/Investigation Date _____
Report/Investigation Number _____

C. *INJURY (15 through 22)*

15. What caused the injury: (*check one, specify below*)
☐ Bite ☐ Burn
☐ Contact/collision with ☐ Person or ☐ Object
☐ Drowning ☐ Near-Drowning
☐ Fall ☐ Trip/Slip
☐ Hazardous Material Exposure
☐ Poisoning ☐ Weapon ☐ Other (*specify*)
*specify by what*_____

16. Was the injury:
☐ Unintentional (*accidental*)
☐ Intentional (*self-inflicted*)
☐ Intentional (*inflicted by another*)

17. Did the individual sustain a (*check all that apply*):
☐ Concussion ☐ Other Head Injury
☐ Spinal Cord Injury ☐ Loss of Consciousness
☐ Severe Laceration ☐ Fracture
☐ None of above

18. Specify the body part(s) injured:
_____

19. Describe where the injury occurred:
☐ On Site ☐ Off Site
(*specify location*) _____

20. Specify the activity the individual was engaged in at the time of injury (*select most applicable activity*):
☐ Archery
☐ Arts & Crafts
☐ Biking
☐ Boating (*specify*) _____
☐ Competitive Sport/Game (*specify*):
_____
☐ Cooking/Food Preparation
☐ Fighting
☐ General Camp Life (*specify*) _____
☐ Groundskeeping/Maintenance (*staff only*)
☐ Gymnastics/Dance/Cheerleading
☐ Horseback Riding

20. Continued
☐ Motorized Vehicle (*specify*)
_____
☐ Playground
☐ Primitive Camping
☐ Riflery
☐ Rock Climbing/Rappelling
☐ Ropes Course/Challenge Course/Zip-line
☐ Swimming
☐ Walking/Running/Hiking
☐ Other (*specify*)
_____

21. Was the activity supervised?
☐ Not Applicable ☐ No
☐ Yes (*specify*) # of campers in activity _____
# of staff in activity_____

22. Was the individual using safety equipment?
☐ No ☐ Not Applicable
☐ Yes (*specify*) _____

D. *ILLNESS*

23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.
A. Was the illness a suspected reportable disease, condition or outbreak? ☐ No ☐ Yes
For the required DHMH reportable diseases list and outbreak information-go to: http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/ReportableDisease_HCP.pdf
B. Was the illness reported to a local health department? ☐ No ☐ Yes If Yes (*specify department*):_____
The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/DHMH1140.pdf

E. *MEDICATION ERROR*

24. Right Patient? ☐ No ☐ Yes; Right Medication? ☐ No ☐ Yes; Right Time? ☐ No ☐ Yes; Right Dose? ☐ No ☐ Yes; Right Route? ☐ No ☐ Yes
25. Type of administration: ☐ Self-Administration: Was camp staff supervising the self-administration? ☐ No ☐ Yes Was medication secured? ☐ No ☐ Yes
☐ Staff administration: Staff person's training level (*check one*): ☐ Office of child care (6 hour course) ☐Certified Medication Technician ☐ LPN ☐ RN ☐ CNP

F. *EPINEPHRINE*

26. Who administered the epinephrine? Name and Title: _____
27. Was the epinephrine prescribed to: the individual? ☐ or the Camp, Epinephrine Certificate Holder? ☐ No ☐ Yes
28. Trigger: ☐ Unknown or ☐ Known: *(specify):* _____
29. Symptoms (*check all that apply*): ☐ Skin reaction, ☐ Feeling of warmth, ☐ Sensation of a lump in the throat, ☐ Constriction of the airway, swollen tongue, trouble breathing, ☐ Rapid pulse, ☐ Nausea, vomiting or diarrhea, ☐ Dizziness or fainting

30. Report Completed By-Employee Name (print) Title

31. Camp Name Address DHMH CAMP ID #

32. Notification

Parent, Guardian, or Emergency Contact was notified		☐ No ☐ Yes	Date	Method
Camp Health Supervisor was notified	☐ No ☐ Yes ☐ Not Applicable	Health Supervisor Name	Date	Method
DHMH/CHS was notified within 24 hours	☐ No ☐ Yes ☐ Not Applicable	DHMH Contact Name	Date	Method

33. Employee Signature Date Phone Number

Maintain this report for at least 3 years.