

**MARYLAND YOUTH CAMP
INJURY OR ILLNESS REPORT FORM**

Department of Health and Mental Hygiene (DHMH)/Center for Consumer Health Services (CHS)
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

► Before forwarding this report to DHMH, remove confidential information such as the person's name or other personal identifiers.

A. PERSONAL INFORMATION			
1. Name (<i>print</i>)	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper <input type="checkbox"/> Camp Employee <input type="checkbox"/> Other:
B. INCIDENT INFORMATION Complete items 5 through 14 for an injury, illness or medication error.			
5. Report Type (<i>check one</i>) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Medication Error		6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
8. For injuries, specify how the injury occurred and what the injured person was doing at the time of the incident. For illnesses, specify the symptoms and/or relevant medical conditions. For medication errors, specify medication and dose given and symptoms, if any.			
<input type="checkbox"/> Additional information attached			
9. Did the incident require any of the following: CPR - <input type="checkbox"/> No <input type="checkbox"/> Yes Epinephrine- <input type="checkbox"/> No <input type="checkbox"/> Yes AED - <input type="checkbox"/> No <input type="checkbox"/> Yes Inhaler- <input type="checkbox"/> No <input type="checkbox"/> Yes		C. Complete items 15 through 22 only for an injury. See item 23 for an illness.	
10. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes List Date of death: / / List Time of death: <input type="checkbox"/> am/ <input type="checkbox"/> pm		15. What was the cause of injury: <input type="checkbox"/> Bite (<i>by what</i>) _____ <input type="checkbox"/> Burn (<i>by what</i>) _____ <input type="checkbox"/> Contact/collision with Person <input type="checkbox"/> Contact/collision with Object (<i>specify</i>) _____ <input type="checkbox"/> Drowning or Near-Drowning <input type="checkbox"/> Fall (<i>from what</i>) _____ <input type="checkbox"/> Hazardous Material Exposure (<i>specify</i>) _____ <input type="checkbox"/> Poisoning(<i>by what</i>) _____ <input type="checkbox"/> Trip/Slip (<i>on what</i>) _____ <input type="checkbox"/> Weapon (<i>by what</i>) _____ <input type="checkbox"/> Other (<i>specify</i>) _____	
11. Was the person transported off-site for medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete A. and B. A. Transported by: <input type="checkbox"/> Camp or personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter B. Treated or evaluated at (<i>check all that apply, specify the name of facility</i>): <input type="checkbox"/> Urgent Care Facility _____ <input type="checkbox"/> Doctor's Office _____ <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Other (<i>specify</i>) _____		16. Was the injury: <input type="checkbox"/> Unintentional (<i>accidental</i>) <input type="checkbox"/> Intentional (<i>self-inflicted</i>) <input type="checkbox"/> Intentional (<i>inflicted by another</i>)	
12. After off-site or on-site medical evaluation, the person (<i>check all that apply</i>): <input type="checkbox"/> Was admitted to the hospital <input type="checkbox"/> Went home. Date _____ <input type="checkbox"/> Returned to camp with medical restrictions <input type="checkbox"/> Returned to camp with no restrictions		17. Did the individual sustain a (<i>check all that apply</i>): <input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> None of above	
13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes		18. Specify the body part(s) injured: _____	
14. Did the incident prompt a report or investigation by government authorities or officials? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>specify</i>) Government Agency _____ Report/Investigation Date _____ Report/Investigation Number _____		19. Describe where the injury occurred: <input type="checkbox"/> On Site <input type="checkbox"/> Off Site <i>(specify location)</i> _____	
		20. Specify the activity the individual was engaged in at the time of injury (<i>select most applicable activity</i>): <input type="checkbox"/> Archery <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Biking <input type="checkbox"/> Boating (<i>specify</i>) _____ <input type="checkbox"/> Competitive Sport/Game (<i>specify</i>): _____ <input type="checkbox"/> Cooking/Food Preparation <input type="checkbox"/> Fighting <input type="checkbox"/> General Camp Life (<i>specify</i>) _____	
		20. Continued <input type="checkbox"/> Groundskeeping/Maintenance (<i>staff only</i>) <input type="checkbox"/> Gymnastics/Dance/Cheerleading <input type="checkbox"/> Horseback Riding <input type="checkbox"/> Motorized Vehicle (<i>specify</i>) _____ <input type="checkbox"/> Playground <input type="checkbox"/> Primitive Camping <input type="checkbox"/> Riflery <input type="checkbox"/> Rock Climbing/Rappelling <input type="checkbox"/> Ropes Course/Challenge Course/Zip-line <input type="checkbox"/> Swimming <input type="checkbox"/> Walking/Running/Hiking <input type="checkbox"/> Other (<i>specify</i>) _____	
		21. Was the activity supervised? <input type="checkbox"/> Not Applicable <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>specify</i>) _____ Number of campers in activity _____ Number of staff in activity _____	
		22. Was the individual using safety equipment? <input type="checkbox"/> Not Applicable <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>specify</i>) _____	
		D. Complete item 23 for an illness, not for an injury.	
		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? <input type="checkbox"/> No <input type="checkbox"/> Yes For the required DHMH reportable diseases list and outbreak information-go to: http://ideha.dhmh.maryland.gov/reportable-diseases.aspx B. Was the illness reported to a local health department? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes (<i>specify department</i>): _____ The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to: http://ideha.dhmh.maryland.gov/pdf/what-to-report/DHMH1140.pdf	
E. GENERAL REPORT INFORMATION Complete items 24 through 27 for an injury, illness or medication error.			
24. Report Completed By-Employee Name (<i>print</i>)			Title
25. Camp Name		Address	DHMH CAMP ID #
26. Notification	Parent, Guardian, or Emergency Contact was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____ Method _____
	Camp Health Supervisor was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Health Supervisor Name _____ Date _____ Method _____
	DHMH/CHS was notified within 24 hours	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	DHMH Contact Name _____ Date _____ Method _____
27. Employee Signature		Date	Phone Number