

# MARYLAND YOUTH CAMP INJURY OR ILLNESS 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

► Before forwarding this report to DHMH, remove name from items 1 and 8.

<b>A. PERSONAL INFORMATION</b>					
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>B. INCIDENT INFORMATION Complete items 5 through 14 for an injury, illness or medication error.</b>					
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					
<b>9. Did the incident require any of the following:</b> 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			<b>C. Complete items 15 through 22 only for an injury. See item 23 for an illness.</b>		
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> ) _____		
			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> ) _____		
			<b>D. Complete item 23 for an illness, not for an injury.</b>		
			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: <a href="http://phpa.dhmm.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf">http://phpa.dhmm.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf</a> 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: <a href="http://phpa.dhmm.maryland.gov/IDEHSharedDocuments/what-to-report/DHMH1140.pdf">http://phpa.dhmm.maryland.gov/IDEHSharedDocuments/what-to-report/DHMH1140.pdf</a>		
<b>E. GENERAL REPORT INFORMATION Complete items 24 through 27 for an injury, illness or medication error.</b>					
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	