NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection
Children's Camp Program

Illness and Outbreak Report

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*
b. Allergic reaction*
c. Anaphylactic shock*
d. Asthma attack
e. Cardiac
f. Chronic illness or disease*
g. Dental problem/infection
h. Eye infection
i. Gastrointestinal*
j. Mandated reportable communicable disease* (Part 2 10NYCRR)
k. Neurological
l. Parasitic*
m. Respiratory infection
n. Seizure disorder
z. Other*
* Specify_____

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_____

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
b. Emergency Medical Technician
c. First Aider*
d. Licensed Practical Nurse
e. Nurse Practitioner
f. Physician
g. Physician's Assistant
h. Registered Nurse
i. Victim
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*

3. What Treatment was provided? (Indicate as many as apply)

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

	Who (Question E1)	*Specify (when required)	Where (Question E2)	*Specify (when required)	What (Question E3)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

F. INVESTIGATION

Was an On-Site investigation conducted by the Local Health Department? Yes No Date of On-Site Investigation: ____/____/____

Did the Local Health Department conduct a telephone follow-up? Yes No Date of Follow-up: ____/____/____

G. NARRATIVE- When entering the narrative into eHIPS, do not include the full names of people involved with the incident. Use the first and last name initials or other similar code.

Provide a description of the illness. Include details of onset, treatment and resolution (returned to camp or went home). For foodborne outbreak investigations, follow Environmental Health Manual Procedure 803 in addition to completing this report.

Information received by: _____Title:_____

Report reviewed by: _____Title:_____