A. PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)</th>
<th>A1. Age</th>
<th>A2. Gender</th>
<th>A3. Check One</th>
<th>Day Camper</th>
<th>Residential Camper</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

B. INCIDENT INFORMATION

Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.

<table>
<thead>
<tr>
<th>B1. Report Type (check one)</th>
<th>B2. Date of Incident/ Illness Onset</th>
<th>B3. Time of Incident/Illness Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epinephrine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B5. Did the incident require any of the following: AED: ☐ No ☐ Yes CPR: ☐ No ☐ Yes Epinephrine: ☐ No ☐ Yes Inhaler: ☐ No ☐ Yes

B6. 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 name of facility):
☐ Urgent Care ☐ Doctor’s Office
☐ Hospital ☐ Other (specify)

B7. 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

B8. Did incident result in death?
☐ No ☐ Yes List Date of death: / / List Time of death: ☐ AM ☐ PM

C. INJURY (15 through 22)

<table>
<thead>
<tr>
<th>C1. What caused the injury: (check one, specify below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bite ☐ Burn ☐ Contact/collision ☐ Person or ☐ Object</td>
</tr>
<tr>
<td>Drowning ☐ Near-Drowning ☐ Fall ☐ Trip/Slip ☐ Hazardous Material Exposure</td>
</tr>
<tr>
<td>Poisoning ☐ Weapon ☐ Other (specify)</td>
</tr>
<tr>
<td>specify by what__________________</td>
</tr>
</tbody>
</table>

C2. Was the injury:
☐ Unintentional (accidental) ☐ Intentional (self-inflicted)
☐ Intentional (inflicted by another)

C3. 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

C4. Specify the body part(s) injured:

C5. Injury occurred:
☐ On Site ☐ Off Site (specify location)

C6. 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) ☐ Groundkeeping/Maintenance (staff only)
☐ Gymnastics/Dance/Cheerleading ☐ Horseback Riding

C7. Was the activity supervised?
☐ Not Applicable ☐ Yes ☐ No ☐ Not applicable ☐ Other (specify)

C8. Was the individual using safety equipment?
☐ No ☐ Yes

D. ILLNESS

D1. MDH 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 MDH reportable diseases list and outbreak information-go to: [http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf](http://phpa.health.maryland.gov/IDEHSharedDocuments/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.health.maryland.gov/IDEHSharedDocuments/what-to-report/DH/H1140.pdf](http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/DH/H1140.pdf)

E. MEDICATION ERROR

E1. Right Patient? ☐ No ☐ Yes, Right Medication? ☐ No ☐ Yes, Right Time? ☐ No ☐ Yes, Right Dose? ☐ No ☐ Yes, Right Route? ☐ No ☐ Yes

E2. Type of administration:
☐ Self-Administration: ☐ Staff administering 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

F1. Who administered the epinephrine? Name and Title:

F2. Was the epinephrine prescribed to: ☐ the individual ☐ or ☐ the Camp, Epinephrine Certificate Holder? ☐ No ☐ Yes

F3. Trigger:
☐ Unknown ☐ Known (specify):

F4. 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

F5. Report Completed By-Employee Name (print) ☐ Title

F6. Camp Name ☐ Address ☐ MDH CAMP ID #

F7. Camp Health Supervisor was notified: ☐ No ☐ Yes ☐ Not Applicable

F8. MDH/CHS was notified within 24 hours: ☐ No ☐ Yes ☐ Not Applicable

F9. Employee Signature Date ☐ Phone Number

[Stay on top of the health and safety regulations by maintaining this report for at least 3 years.]