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.*

A. PERSONAL INFORMATION

1. Name (*print*)	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 or medication error.*

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

☐ ***Additional information attached***

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

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

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

12. 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

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. *Complete items 15 through 22 only for an injury. See item 23 for an illness.*

15. What was the cause of injury:
☐ Bite (*by what*)_____
☐ Burn (*by what*)_____
☐ Contact/collision with Person
☐ Contact/collision with Object (*specify*)
_____
☐ Drowning or Near-Drowning
☐ Fall (*from what*)_____
☐ Hazardous Material Exposure (*specify*)
☐ Poisoning(*by what*)_____
☐ Trip/Slip (*on what*)_____
☐ Weapon (b*y what*)_____
☐ Other (*specify*)_____

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*) _____

20. Continued
☐ Groundskeeping/Maintenance (*staff only*)
☐ Gymnastics/Dance/Cheerleading
☐ Horseback Riding
☐ 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*)
Number of campers in activity _____
Number of staff in activity_____

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

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? ☐ 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. GENERAL REPORT INFORMATION *Complete items 24 through 27 for an injury, illness or medication error.*

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

25. Camp Name Address DHMH CAMP ID #

26. Notification

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

27. Employee Signature Date Phone Number

Maintain this report for at least 3 years.