NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Children's Camps Illness and Outbreak Report

INSTRUCTIONS: Use this form to report all camper and staff illness suspected of being water-, food-, or air-borne, or spread by contact.

SECTION A: FACILITY INFORMATION

Camp Name: _____ **Facility Code:** _____

Camp Address: _____ **Date Reported:** _____

SECTION B: EVENT INFORMATION

Type of Incident: ☐ Illness (single case) ☐ Illness Outbreak (multiple cases) **Date of Incident/Onset:** _____ **Time of Occurrence/Onset** (Military time)**:** _____

SECTION C-1: CASE INFORMATION

Note: For illness outbreak, utilize this form for the event information and initial case, complete section C-2 and complete form DOH-61G (Children's Camps Outbreaks Case Histories Report).

The box below contains confidential information that must be collected by the LHD for follow-up, and will be protected against unauthorized disclosure.

Name of Case (Last, First, MI): _____ **Name of Parent or Guardian (Last, First, MI):** _____

Home Address: _____ **Home Phone Number:** _____

Age: _____ **Gender:** ☐ Female ☐ Male ☐ X ☐ Other **Status:** ☐ Camper ☐ Developmentally Disabled Camper ☐ CIT/Jr. Counselor ☐ Counselor ☐ Other Staff* ☐ Other*

***For status types marked with an asterisk, please specify the individual's role:** _____

SECTION C-2: OUTBREAK INFORMATION

Number of Ill Campers: Female _____ Male _____ X _____ Other _____ **Number of Ill Staff:** Female _____ Male _____ X _____ Other _____

Number of Ill Others: Female _____ Male _____ X _____ Other _____

SECTION 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*

***For illness types marked with an asterisk, please provide the specific name or description of the illness:** _____

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 when marked with an asterisk:** _____

SECTION 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 (specify number)
z. Other*

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

SECTION F. NARRATIVE - Note to LHD: 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. For foodborne outbreak investigations, follow Environmental Health Manual Procedure 803 in addition to completing this report.

Provide a description of the illness. Include details of onset, treatment and resolution (returned to camp or went home).

LHD USE ONLY (Note: eHIPS will assign the incident and victim ID numbers when entered into the system.)

eHIPS Incident #: _____ **eHIPS Victim ID #:** _____

Information received by: _____ **Title:** _____

Report reviewed by: _____ **Title:** _____

INVESTIGATION/FOLLOW-UP SERVICE:

Inspector's Name: _____

Date of Service: _____ **Hours:** _____ **Service:** ☐ On-site Investigation ☐ Telephone Follow-up

Inspector's Name: _____

Date of Service: _____ **Hours:** _____ **Service:** ☐ On-site Investigation ☐ Telephone Follow-up