

INSTRUCTIONS: Use this form to report camper or staff epinephrine administrations, regardless of whether medication was from the camp's stocked supply or brought to camp by an individual, or where it was administered (e.g., at the camp, hospital, etc.).

SECTION A: FACILITY INFORMATION

Camp Name: _____
Camp Address: _____
Facility Code: _____ Incident Date: _____ Time of Occurrence (Military time): _____
Date Reported to Local Health Department: _____
Location of Incident: In Camp Out-of-Camp Specify location: _____

SECTION B: VICTIM INFORMATION

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 Victim (Last, First, MI): _____
Name of Parent or Guardian (Last, First, MI): _____
Home Address: _____
Home Phone Number: _____

Age: _____ Weight: _____ lbs 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: EVENT INFORMATION

Type of Incident Resulting in Need to Administer Epinephrine:
 Bee Sting Other Insect Bite* Asthma Attack Food Allergy* Other*
*For incident types marked with an asterisk, please describe: _____
Time Epinephrine administered (Military time): _____ Number of auto-injector administrations: _____
Type of Epinephrine Auto-injector: Adult Pediatric
Where on body was epinephrine injected? Thigh/Buttock Other (specify): _____
Indicate source of Epinephrine: Camp supply Patient prescription Other (specify): _____
Epinephrine Administered by: Name: _____
Indicate applicable certification(s): Doctor Nurse Practitioner Physician's Assistant RN LPN EMT
 First Aid Certified Staff Self-Administered Other (specify): _____
Epinephrine training course: NYSDOH EMS (training program outline) None
 Other (specify): _____
Was EMS contacted? Yes No
Was patient transported to a healthcare facility? Yes No
Was patient admitted? Yes No

SECTION D: 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.

Use this form to describe symptoms and circumstances surrounding the administration of epinephrine including the cause of anaphylaxis, signs and symptoms displayed by the patient prior to administration, and the patient's response to the administered drug. Enter the events in the chronological order of their occurrence. Include available information about the event's outcome such as whether the patient was discharged from the hospital, returned to camp or went home. Use additional sheets if needed.

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: <input type="checkbox"/> On-site Investigation <input type="checkbox"/> Telephone Follow-up
Inspector's Name: _____	
Date of Service: _____	Hours: _____ Service: <input type="checkbox"/> On-site Investigation <input type="checkbox"/> Telephone Follow-up