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

Illness and Outbreak Report

INSTRUCTIONS: Report all camper and staff illness suspected of being water-, food-, or air-borne, or spread by contact.

A. FACILITY INFORMATION

eHIPS Incident Number: _____ (LHD use only)

Camp Name:_____ Facility Code:_____

Camp Address_____ Date Reported _____

B. EVENT INFORMATION

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-61g.

eHIPS Victim ID Number:_____ (LHD use only)

C-1. VICTIM INFORMATION - Material in Shaded area is confidential

Name of Victim (Last, First, MI):_____

Home Address:_____

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

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

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

*Specify_____

2. Outbreak Information

Number of campers: Female _____ Male _____ Gender X _____ Other _____ **Number of staff:** Female _____ Male _____ Gender X _____ Other _____

Number of others: Female _____ Male _____ Gender X _____ Other _____

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.

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

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