

**Instructions: See Instructions on back of form prior to completing**

eHIPS Incident Number: \_\_\_\_\_

## FACILITY INFORMATION

Camp Name: \_\_\_\_\_ Facility Code: \_\_\_\_\_

Camp Type:  Day  Overnight    Camp for developmentally disabled?  Yes  No    Date Reported \_\_\_\_/\_\_\_\_/\_\_\_\_  
to Local Health Department

Incident Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Incident Time: \_\_\_\_:\_\_\_\_ (Military time)

Location of Incident:  In Camp  Out-of-Camp    Specify: \_\_\_\_\_

Does the camp participate in the Epinephrine administration program?  Yes  No

## VICTIM INFORMATION

eHIPS Victim ID: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Home Address Street \_\_\_\_\_

Town, Village or City \_\_\_\_\_ State \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Home Phone Number (\_\_\_\_) \_\_\_\_\_

**Material in shaded area is confidential**

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Female  Male

Status:  Camper  Developmentally Disabled Camper  CIT/Jr. Counselor  Counselor  Other Staff\*  
 Other\* \_\_\_\_\_ Specify for \* \_\_\_\_\_

## EVENT INFORMATION

Type of Incident Resulting in Need to Administer Epinephrine:

Bee Sting  Other Insect Bite \*  Asthma Attack  Food Allergy\*  Other\*

\* Specify: \_\_\_\_\_

Time Epinephrine administered: \_\_\_\_:\_\_\_\_ (Military time)    Number of auto-injector administrations: \_\_\_\_\_

Type of Epinephrine Injector:  Epi-pen®  Epi-pen Jr.®  Other Specify: \_\_\_\_\_

Where on body was epinephrine injected? \_\_\_\_\_

Indicate source of Epinephrine:  Camp Supply  Patient Prescription  EMS supply  Hospital Supply  
 Other Specify: \_\_\_\_\_

Epinephrine Administered by: Name: \_\_\_\_\_ Indicate applicable certification(s) below

Doctor  Nurse Practitioner  Physician's Assistant  RN  LPN  EMT  First Aid Certified Staff

Self-Administered  Other \_\_\_\_\_

Epinephrine training course:  NYS EMS  Red Cross  None  Other \_\_\_\_\_

Name of EMS agency providing care: \_\_\_\_\_ Phone: \_\_\_\_\_

Name and location of health care facility patient was transported to: \_\_\_\_\_

Was patient admitted?  Yes  No

**Narrative: Provide a written description of the event on back of form.**

## Instructions for completing the Children's Camp Epinephrine Administration Report

Local health department staff are responsible for completion of the form and submittal to the Bureau of Community Sanitation and Food Protection. Victim information is confidential and must be protected from unauthorized disclosure.

Children's camps must report epinephrine administration to the local health department whether or not they are participating in the auto injector program and regardless if medication was from the camp's stocked supply or brought to camp by a camper or staff.

### **Description of Incident:**

**Describe symptoms and circumstances surrounding the administration of the 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. When entering the narrative into eHIPS do not enter confidential information. Use the victim's initials or similar code.**

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<b>Report completed by:</b> _____	<b>Title:</b> _____	<b>Date:</b> ____ / ____ / ____
<b>Local Health Department:</b> _____	<b>Phone:</b> (____) _____	