

Youth Camp Incident Report

DPH D/E by _____ ____/____/____

The following incidents are required to be reported to the Department per 19-13-B27a(u).

1. Any fatality which occurs at camp or results from camping activities; or
2. Any injury or illness which occurs at the camp or which results from camping activities and is attended by a physician, nurse or person in charge of health care at the camp and results in hospital admission, camper/staff being sent home (residential camps only) or a positive diagnosis as demonstrated through clinical report, laboratory analysis or X-ray.

Completion of all fields in report is required
General Information

Camp Information	Information on Injured or Ill Person
Date of this Report ____/____/____	<input type="checkbox"/> Camper <input type="checkbox"/> Staff
Date of Incident ____/____/____	If Staff, Title or Position _____
License Number YCYC _____	First Name _____ Tel#(____) _____
Camp Town _____	Last Name _____ DOB ____/____/____
Camp Name _____ <i>(please enter the name that appears on the camp license)</i>	Name of Parent/Guardian Contacted:
If more than one Program or Site, indicate at which program or site the incident occurred: _____	First Name _____ Tel#(____) _____
	Last Name _____ Relationship _____

Reason for Report: Fatality Hospital Admission Injury or Illness resulting in evaluation by medical personnel and camper going home or receiving positive clinical diagnosis. Other _____

Diagnosis resulting from injury:

- Burn Contusion (bruise) Concussion Dislocations Fracture Laceration
 Sprain/strain Stitches/Staples Other _____

Description of injury and affected area of body _____

Location of incident resulting in injury: (Please be specific, ie. Athletic field, cabin #, mess hall, etc.)

Supervision at the time of incident: Adult staff CIT staff Other (Describe) _____

Names of all camp staff who witnessed the incident: _____

Description of incident (To be completed by person witnessing incident): _____

License # _____ First Name Patient _____ Last Name Patient _____

Diagnosis resulting from illness: (* Please describe in "other" if origin is known, for example, "chicken pox" for rash or "exposure to peanuts" for allergy)

- Allergy * Asthma Ear infection Food Borne Illness* GI Illness Lyme Disease
 Rash* Strep Throat Viral Infection **Other (Describe)** _____

Name of staff member(s) illness was reported to: _____

Description of complaint (signs and symptoms): _____

Name of person(s) providing treatment for injury or illness: _____

Description of treatment provided for injury or illness: _____

Name of person(s) and/or agency contacted regarding injury or illness other than parent/guardian (i.e. camp personnel, off site medical personnel/facility):

Were changes made in the camp, its environment or its operation as a result of this incident?

NO YES If yes, please explain: _____

Person Completing This Form _____ **Title/Position** _____
(Please Print)

Signature _____ **Date** ____/____/____

Phone # (____) _____ - _____ **Fax Number** (____) _____ - _____

Date Phone Report Made to DPH ____/____/____ **Youth Camp Licensing Fax # (860) 509-8212**

This information shall be reported to the Department within 24 hours via telephone by the camp director at (860) 509-8045. . In addition, a copy of this completed and signed written report shall be submitted to the Department within seventy-two hours. **The original report form shall be maintained at the camp or sponsoring organization for at least two years.** Mail completed and signed reports that have not been faxed to:

Department of Public Health
Community Based Regulations Section
Youth Camp Licensing Program
P. O. Box 340308, 410 Capitol Ave MS #12 CBR
Hartford, CT 06134-0308