Westchester gov.com

George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

Westchester County Department of Health

Children's Camp Workshop 2020

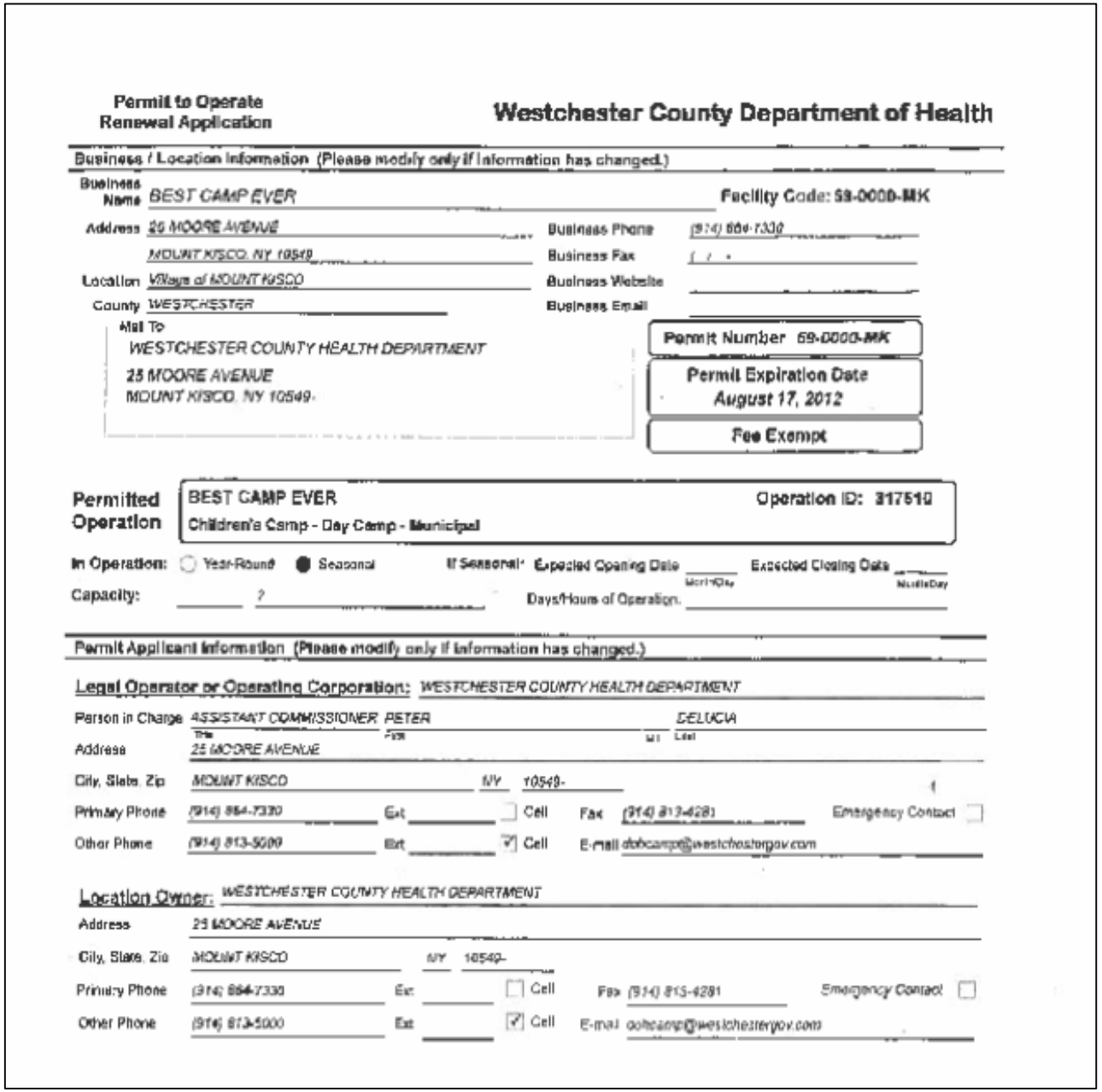
Westchester County Department of Health

Summer Camp Permit Application

If it’s not complete, it will not be approved.
A review fee may be imposed for multiple submittals.

Permit to Operate Renewal Application

- Make sure all of the information is correct.
- Cross out incorrect information.
- Add correct information including email address for inspection reports.
- Must include dates and times of operation.



Permit to Operate Renewal Application

Westchester County Department of Health

Business / Location Information (Please modify only if information has changed.)

Business Name: BEST CAMP EVER — Facility Code: 59-0000-MK

Address: 25 MOORE AVENUE — Business Phone: (914) 864-7330

MOUNT KISCO, NY 10549 — Business Fax:

Location: Village of MOUNT KISCO — Business Website:

County: WESTCHESTER — Business Email:

Mail To:
WESTCHESTER COUNTY HEALTH DEPARTMENT
25 MOORE AVENUE
MOUNT KISCO, NY 10549-

Permit Number: 59-0000-MK

Permit Expiration Date: August 17, 2012

Fee Exempt

Permitted Operation

BEST CAMP EVER — Operation ID: 317519

Children's Camp - Day Camp - Municipal

In Operation: ○ Year-Round ● Seasonal — If Seasonal: Expected Opening Date: ____ (Month/Day) — Expected Closing Date: ____ (Month/Day)

Capacity: ____ ? — Days/Hours of Operation: ____

Permit Applicant Information (Please modify only if information has changed.)

Legal Operator or Operating Corporation: WESTCHESTER COUNTY HEALTH DEPARTMENT

Person in Charge: ASSISTANT COMMISSIONER (Title) PETER (First) (MI) DELUCIA (Last)

Address: 25 MOORE AVENUE

City, State, Zip: MOUNT KISCO NY 10549-

Primary Phone: (914) 864-7330 Ext: ☐ Cell — Fax: (914) 813-4281 — Emergency Contact ☐

Other Phone: (914) 813-5000 Ext: ☑ Cell — E-mail: dohcamp@westchestergov.com

Location Owner: WESTCHESTER COUNTY HEALTH DEPARTMENT

Address: 25 MOORE AVENUE

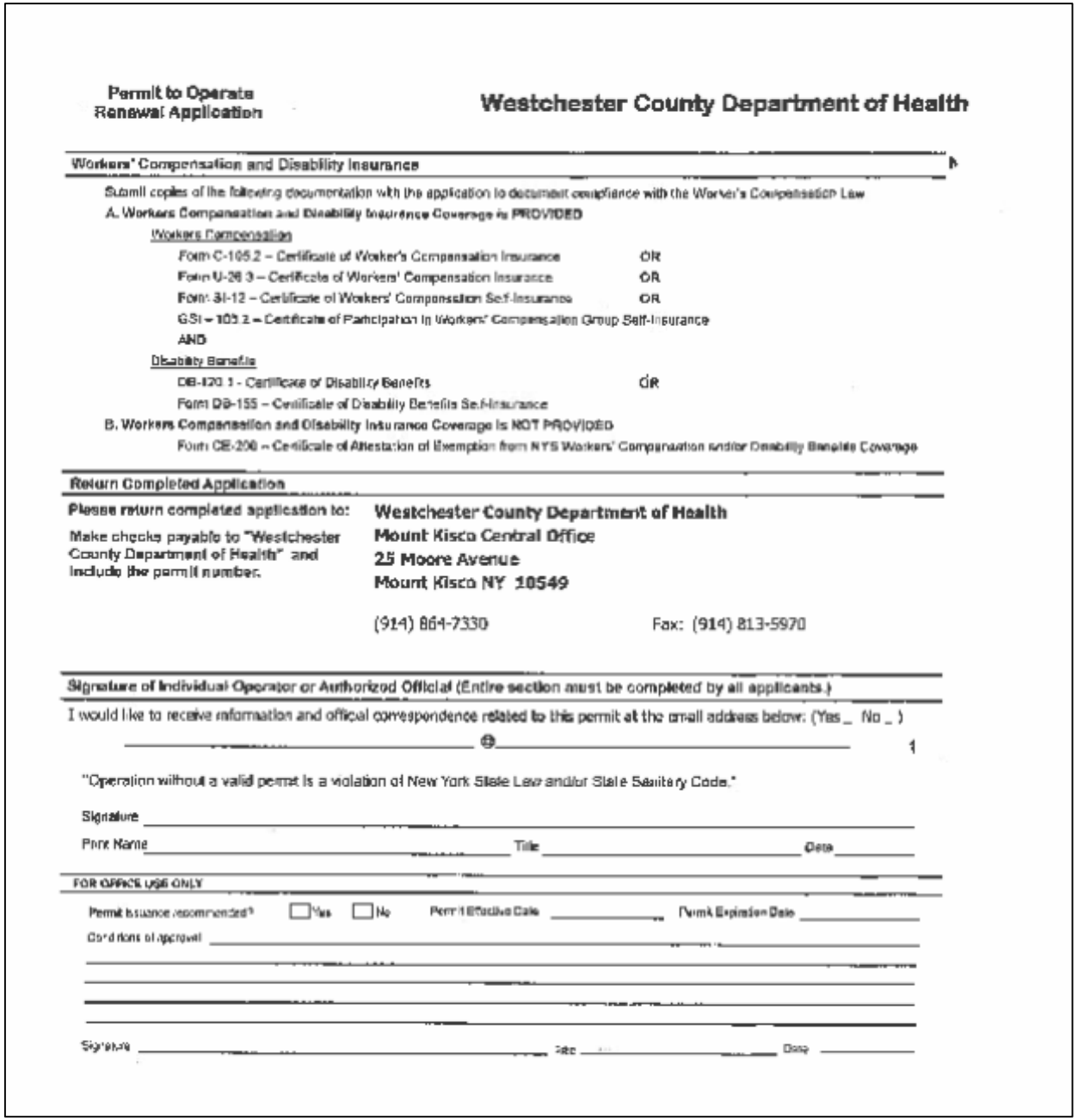
City, State, Zip: MOUNT KISCO NY 10549-

Primary Phone: (914) 864-7330 Ext: ☐ Cell — Fax: (914) 813-4281 — Emergency Contact ☐

Other Phone: (914) 813-5000 Ext: ☑ Cell — E-mail: dohcamp@westchestergov.com

Renewal Application Continued

- Required Insurance Forms:
  - Disability DB-120.1
  - Workers' Compensation C-105.2 OR U-26.3
  - Self Insured DB-155 & SI-12 OR GSI-105.2
  - Insurance Exemption CE-200
- Email address, signature, printed name, title and date.



Permit to Operate
Renewal Application

Westchester County Department of Health

Workers' Compensation and Disability Insurance

Submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law

A. Workers Compensation and Disability Insurance Coverage is PROVIDED

Workers Compensation

Form C-105.2 – Certificate of Worker's Compensation Insurance OR
Form U-26.3 – Certificate of Workers' Compensation Insurance OR
Form SI-12 – Certificate of Workers' Compensation Self-Insurance OR
GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance
AND

Disability Benefits

DB-120.1 - Certificate of Disability Benefits OR
Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage is NOT PROVIDED

Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

Return Completed Application

Please return completed application to:

Make checks payable to "Westchester County Department of Health" and include the permit number.

Westchester County Department of Health
Mount Kisco Central Office
25 Moore Avenue
Mount Kisco NY 10549

(914) 864-7330 Fax: (914) 813-5970

Signature of Individual Operator or Authorized Official (Entire section must be completed by all applicants.)

I would like to receive information and official correspondence related to this permit at the email address below: (Yes _ No _)

"Operation without a valid permit is a violation of New York State Law and/or State Sanitary Code."

Signature _____

Print Name _____ Title _____ Date _____

FOR OFFICE USE ONLY

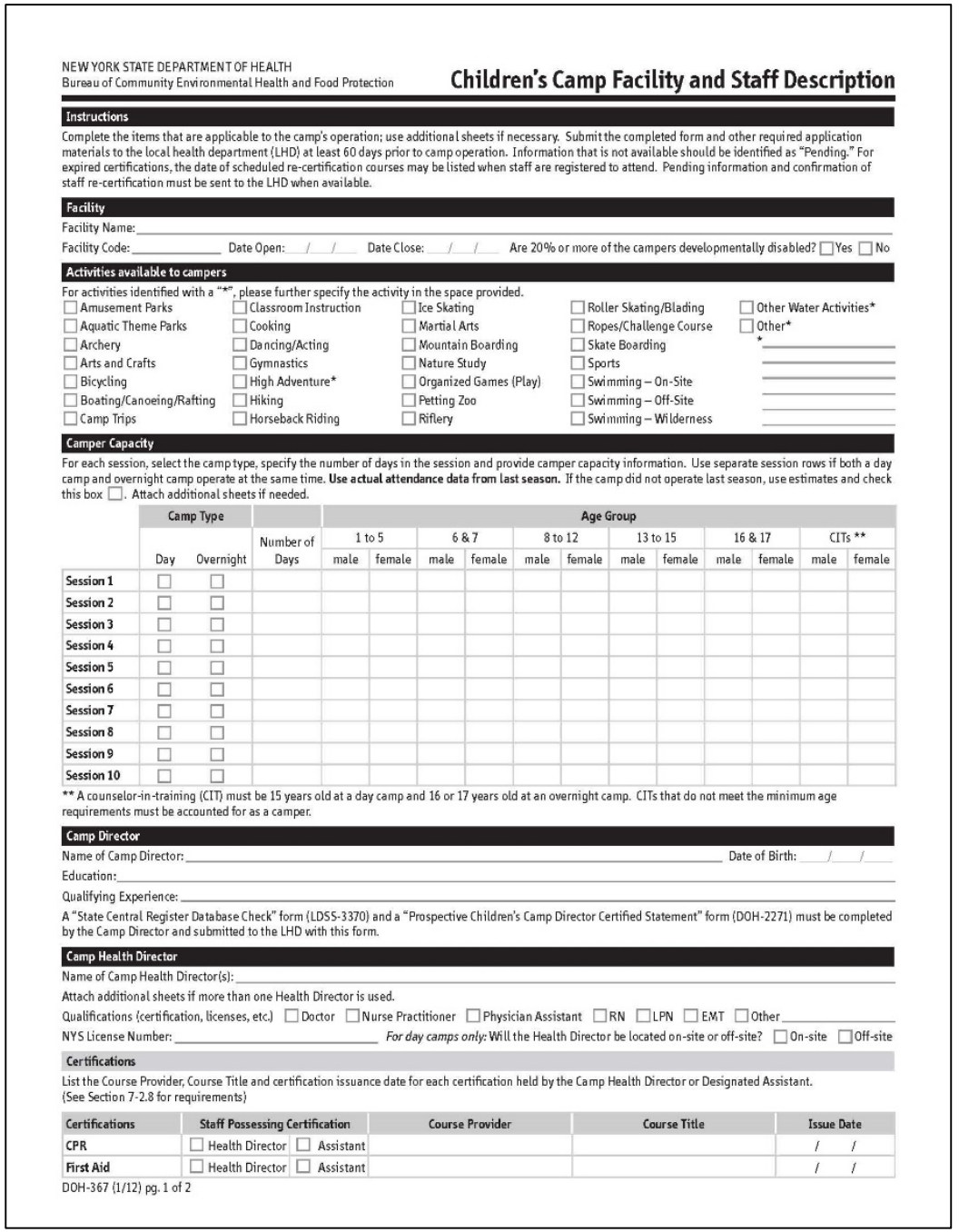
Permit Issuance recommended? ☐ Yes ☐ No Permit Effective Date _____ Permit Expiration Date _____

Conditions of Approval _____

Signature _____ Title _____ Date _____

NYS DOH 367

- ALL sections must be completed.
- Camp Director information must be complete and if a new director is hired, a resume must be included.
- Health director is the licensed medical professional that is required.
- In a Day Camp setting, this can be an off site licensed medical
- Certifications: for the person that will be on-site. Must be from the fact sheets or it is NOT ACCEPTABLE.



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

Children's Camp Facility and Staff Description

Instructions

Complete the items that are applicable to the camp's operation; use additional sheets if necessary. Submit the completed form and other required application materials to the local health department (LHD) at least 60 days prior to camp operation. Information that is not available should be identified as "Pending." For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available.

Facility

Facility Name: _____

Facility Code: _____ Date Open: ___/___/___ Date Close: ___/___/___ Are 20% or more of the campers developmentally disabled? ☐ Yes ☐ No

Activities available to campers

For activities identified with a "*", please further specify the activity in the space provided.

☐ Amusement Parks	☐ Classroom Instruction	☐ Ice Skating	☐ Roller Skating/Blading	☐ Other Water Activities*
☐ Aquatic Theme Parks	☐ Cooking	☐ Martial Arts	☐ Ropes/Challenge Course	☐ Other*
☐ Archery	☐ Dancing/Acting	☐ Mountain Boarding	☐ Skate Boarding	* _____
☐ Arts and Crafts	☐ Gymnastics	☐ Nature Study	☐ Sports	_____
☐ Bicycling	☐ High Adventure*	☐ Organized Games (Play)	☐ Swimming – On-Site	_____
☐ Boating/Canoeing/Rafting	☐ Hiking	☐ Petting Zoo	☐ Swimming – Off-Site	_____
☐ Camp Trips	☐ Horseback Riding	☐ Riflery	☐ Swimming – Wilderness	_____

Camper Capacity

For each session, select the camp type, specify the number of days in the session and provide camper capacity information. Use separate session rows if both a day camp and overnight camp operate at the same time. **Use actual attendance data from last season.** If the camp did not operate last season, use estimates and check this box ☐. Attach additional sheets if needed.

	Camp Type			Age Group											
				1 to 5		6 & 7		8 to 12		13 to 15		16 & 17		CITs **	
	Day	Overnight	Number of Days	male	female	male	female	male	female	male	female	male	female	male	female
Session 1	☐	☐													
Session 2	☐	☐													
Session 3	☐	☐													
Session 4	☐	☐													
Session 5	☐	☐													
Session 6	☐	☐													
Session 7	☐	☐													
Session 8	☐	☐													
Session 9	☐	☐													
Session 10	☐	☐													

** A counselor-in-training (CIT) must be 15 years old at a day camp and 16 or 17 years old at an overnight camp. CITs that do not meet the minimum age requirements must be accounted for as a camper.

Camp Director

Name of Camp Director: _____ Date of Birth: ___/___/___

Education: _____

Qualifying Experience: _____

A "State Central Register Database Check" form (LDSS-3370) and a "Prospective Children's Camp Director Certified Statement" form (DOH-2271) must be completed by the Camp Director and submitted to the LHD with this form.

Camp Health Director

Name of Camp Health Director(s): _____

Attach additional sheets if more than one Health Director is used.

Qualifications (certification, licenses, etc.) ☐ Doctor ☐ Nurse Practitioner ☐ Physician Assistant ☐ RN ☐ LPN ☐ EMT ☐ Other _____

NYS License Number: _____ *For day camps only:* Will the Health Director be located on-site or off-site? ☐ On-site ☐ Off-site

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Health Director or Designated Assistant. (See Section 7-2.8 for requirements)

Certifications	Staff Possessing Certification		Course Provider	Course Title	Issue Date
CPR	☐ Health Director	☐ Assistant			/ /
First Aid	☐ Health Director	☐ Assistant			/ /

DOH-367 (1/12) pg. 1 of 2

NYS DOH 367 continued

- On-site swimming means that the pool is permitted on the camp permit and is ONLY for camp use.
- Aquatics Director is ONLY required for on-site swimming.
- Safety Plan: Do not submit a copy unless changes have been made and approval is required.
- Camp trip itinerary/camp calendar
- Approved written statement or NYS Brochure 3601 to be provided to parents.
- Camp Operator signature.

Aquatics Director

Name of Camp Aquatics Director: _____ Date of Birth: ____/____/____

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Aquatics Director. (See Section 7-2.5(e) for minimum qualifications)

Certifications	Course Provider	Course Title	Issue Date
Lifeguard Supervision and Management*			/ /
Lifeguarding			/ /
Progressive Swimming Instructor			/ /
CPR*			/ /
First Aid			/ /

* The Camp Aquatics Director must possess these certifications to qualify.

Aquatic Experience (check qualifying experience below)

☐ One season of previous experience as a camp aquatics director at a New York State children's camp.
☐ Two seasons of previous experience consisting cumulatively of at least 12 weeks as a children's camp lifeguard, as specified in Section 7-2.5(g), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.
☐ At least 18 weeks of previous experience as a lifeguard, as specified in Section 7-2.5(g)(2), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.

Other Staff Requirements

Subpart 7-2 of the New York State Sanitary Code (Children's Camps) specifies minimum staff ratios and qualifications for counselors, lifeguards, progressive swimming instructors, riflery instructors, and additional first aid and CPR certified staff. When staff are required to possess special certification, a course standard or criteria is specified in the regulation. Certification courses which have been reviewed and meet or exceed the Children's Camp Code standard/criteria, are listed on New York State Department of Health (NYSDOH) "fact sheets." The fact sheets are available from the LHD and at the NYSDOH's website at www.health.ny.gov. Camp operators are responsible for ensuring that required staff are present and possess acceptable certification. A LHD may require a children's camp operator to document staff ratios and qualifications by submitting a Children's Camp Additional Staff Qualifications form (DOH-367a) and/or copies of certification cards. Copies of all required certifications must be maintained on file at the camp.

Written Safety Plan, Facility Additions/Modifications, and Itinerary of Camp Trips

1. Written Safety Plan as required by Section 7-2.5(n)

☐ Plan attached
☐ Previously submitted on ____/____/____. This plan remains up to date and complete.
☐ Update to plan attached

2. Facility Addition/Modifications

Provide a list of additions or modification to the camp that have been made since last season or that are planned prior to this season. Include additions or modifications to buildings (cabins, kitchens, dining halls, infirmary, assembly areas, privies and toilets, etc.), potable water and sewage disposal systems, swimming pools, bathing beaches, activity areas (challenge course, archery and rifle ranges, etc.), emergency access and egress roads and any other camp facilities.

☐ List attached
☐ No Addition/Modifications
☐ Not Applicable. Camp did not operate last season.

3. Itinerary of Camp Trips

Attach a list of camp trips. Describe the activities that will take place (swimming, canoeing, hiking, etc.) and include the trip date(s) when known.

☐ List attached
☐ No trips

Section 7-2.5(p) requires a written statement or brochure outlining the rights and responsibilities of campers and camp operators to be provided to parents or guardians of campers by the camp operator with any enrollment application forms and/or enrollment contract forms. Either a statement or brochure prepared by the camp and approved by the permit-issuing official or the Department of Health brochure "Children's Camps in New York State" may be used. Please check the appropriate box below for the brochure sent with your application materials.

☐ A statement (brochure) which has been submitted to the DOH and approved
☐ "Children's Camps in New York State" Brochure (#3601)

I certify that the information given in this form is true.

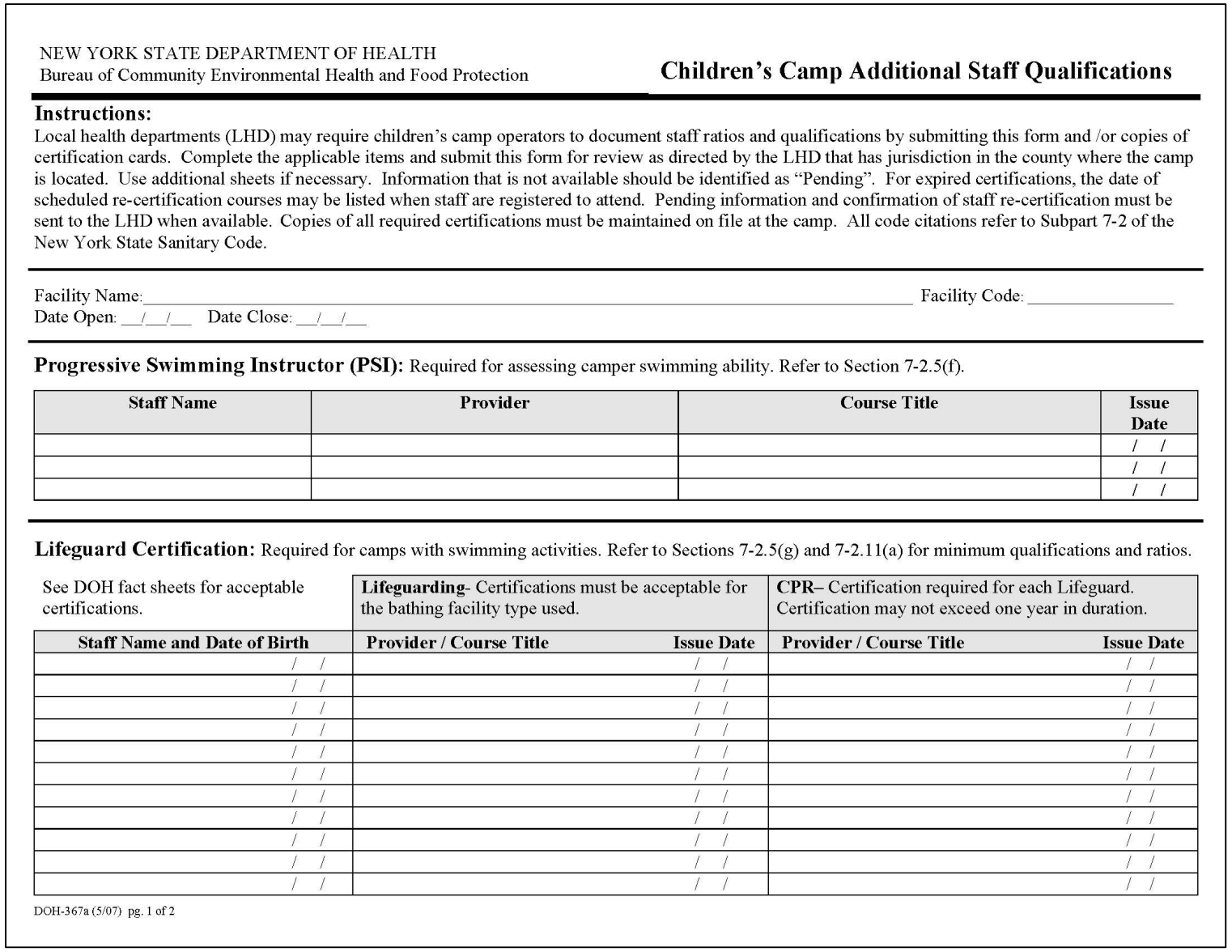
Signature of Camp Operator: _____

Print Name: _____ Title: _____ Date: ____/____/____

DOH-367 (1/12) pg. 2 of 2

NYS DOH 367a

- If campers will be as swimmers and non-swimmers, a PSI must administer the approved swim test. The approved swim test is in the safety plan.
- Specific course providers and course titles must be from the approved fact sheets.
- Adequate ratios must be given for the number of campers present.
- Lifeguarding is valid for 2 years.
- CPR is valid for 1 year from the date of completion regardless of expiration date on certificate.



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

Children's Camp Additional Staff Qualifications

Instructions:
Local health departments (LHD) may require children's camp operators to document staff ratios and qualifications by submitting this form and /or copies of certification cards. Complete the applicable items and submit this form for review as directed by the LHD that has jurisdiction in the county where the camp is located. Use additional sheets if necessary. Information that is not available should be identified as "Pending". For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available. Copies of all required certifications must be maintained on file at the camp. All code citations refer to Subpart 7-2 of the New York State Sanitary Code.

Facility Name:_____ Facility Code: _____
Date Open: __/__/__ Date Close: __/__/__

Progressive Swimming Instructor (PSI): Required for assessing camper swimming ability. Refer to Section 7-2.5(f).

Staff Name	Provider	Course Title	Issue Date
			/ /
			/ /
			/ /

Lifeguard Certification: Required for camps with swimming activities. Refer to Sections 7-2.5(g) and 7-2.11(a) for minimum qualifications and ratios.

See DOH fact sheets for acceptable certifications.	**Lifeguarding**– Certifications must be acceptable for the bathing facility type used.		**CPR**– Certification required for each Lifeguard. Certification may not exceed one year in duration.	
Staff Name and Date of Birth	**Provider / Course Title**	**Issue Date**	**Provider / Course Title**	**Issue Date**
/ /		/ /		/ /
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DOH-367a (5/07) pg. 1 of 2

NYS DOH 367a continued

- Specific course providers and course titles must be from the approved fact sheets.
- Adequate ratios must be given for the number of campers present.
- 1 first aid and 2 CPR staff are required for up to 200 campers and staff.
- CPR is valid for 1 year from date of completion regardless of expiration date on certificate.
- Must include staff data, camp operators signature.

Additional First Aid and CPR Staff: Required for all camps as specified in Section 7-2.8.

See DOH fact sheets for acceptable certifications.	**First Aid** – A minimum of one staff for each 200 campers*		**CPR**- A minimum of one staff for each 200 campers.* Certification may not exceed one year in duration.	
Staff Name and Date of Birth	**Provider / Course Title**	**Issue Date**	**Provider / Course Title**	**Issue Date**
/ /		/ /		/ /
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*Trip and Activity Leaders may also require certification in First Aid and CPR depending on the activity and location. Refer to Sections 7-2.5(h) and 7-2.5(i).

Counselor Data: Required for all camps. List the number of counselors proposed for the camp session with the most campers. Refer to Sections 7-2.5 and 7-2.11 for counselor qualification and ratio requirements.

	Counselors	
Staff Ages	**Male**	**Female**
16 (Day camps only)		
17		
18 & Over		

Riflery Instructor: Required for all camps with riflery activities. Refer to Section 7-2.5(j).

Name: _____ Date of Birth: ___/___/___

Certification: _____ Date Issued: ___/___/___

I certify that the information given in this form is true.

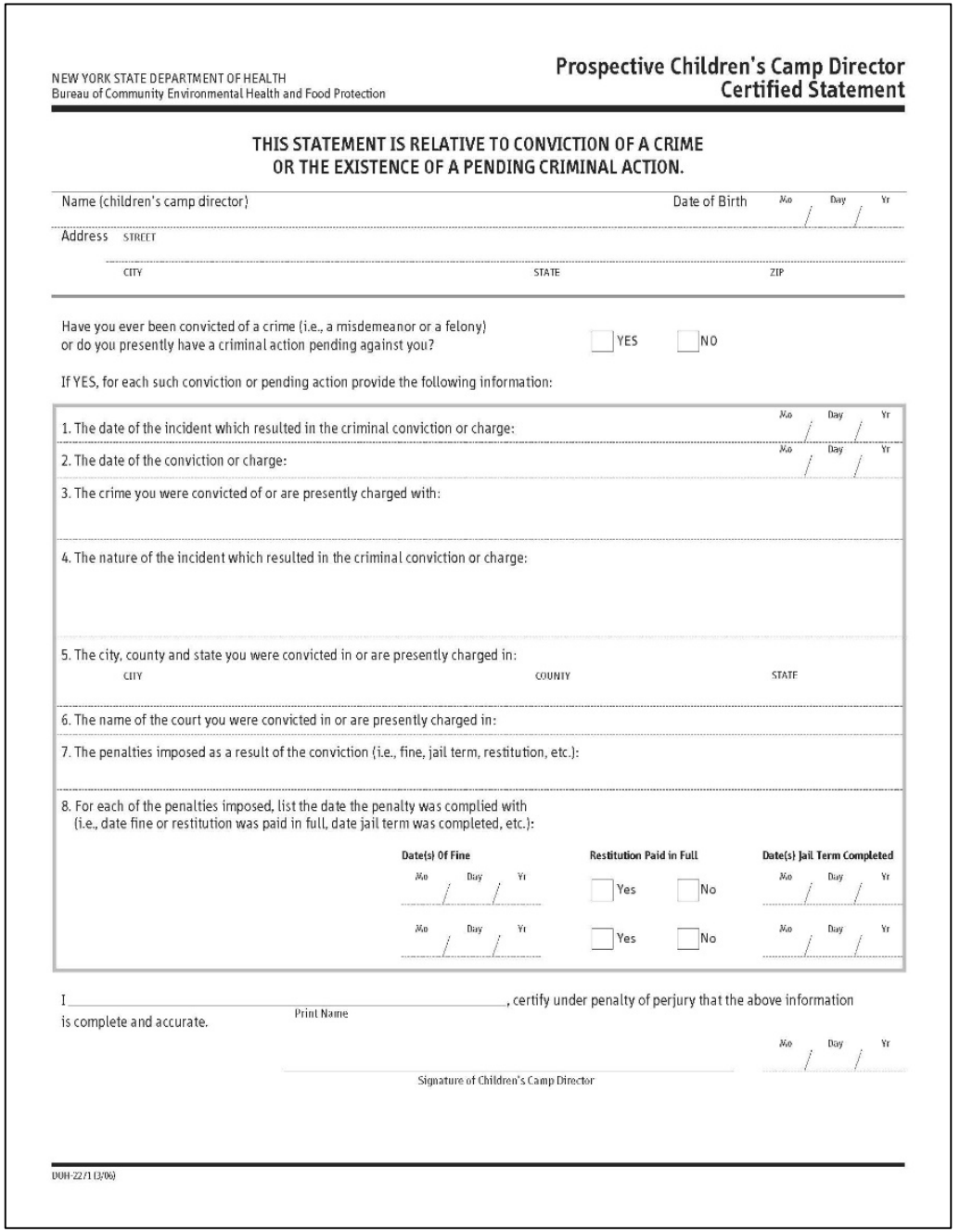
Signature of the individual operator or official operating person: _____

Print Name: _____ Title: _____ Date: ___/___/___

DOH-367a (5/07) pg. 2 of 2

NYS DOH 2271

- This must be competed and signed by the Camp Director.



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

Prospective Children's Camp Director Certified Statement

THIS STATEMENT IS RELATIVE TO CONVICTION OF A CRIME OR THE EXISTENCE OF A PENDING CRIMINAL ACTION.

Name (children's camp director) Date of Birth Mo / Day / Yr

Address STREET

CITY STATE ZIP

Have you ever been convicted of a crime (i.e., a misdemeanor or a felony) or do you presently have a criminal action pending against you? ☐ YES ☐ NO

If YES, for each such conviction or pending action provide the following information:

1. The date of the incident which resulted in the criminal conviction or charge: Mo / Day / Yr
2. The date of the conviction or charge: Mo / Day / Yr
3. The crime you were convicted of or are presently charged with:
4. The nature of the incident which resulted in the criminal conviction or charge:
5. The city, county and state you were convicted in or are presently charged in:
   CITY COUNTY STATE
6. The name of the court you were convicted in or are presently charged in:
7. The penalties imposed as a result of the conviction (i.e., fine, jail term, restitution, etc.):
8. For each of the penalties imposed, list the date the penalty was complied with (i.e., date fine or restitution was paid in full, date jail term was completed, etc.):

Date(s) Of Fine	Restitution Paid in Full	Date(s) Jail Term Completed
Mo / Day / Yr	☐ Yes ☐ No	Mo / Day / Yr
Mo / Day / Yr	☐ Yes ☐ No	Mo / Day / Yr

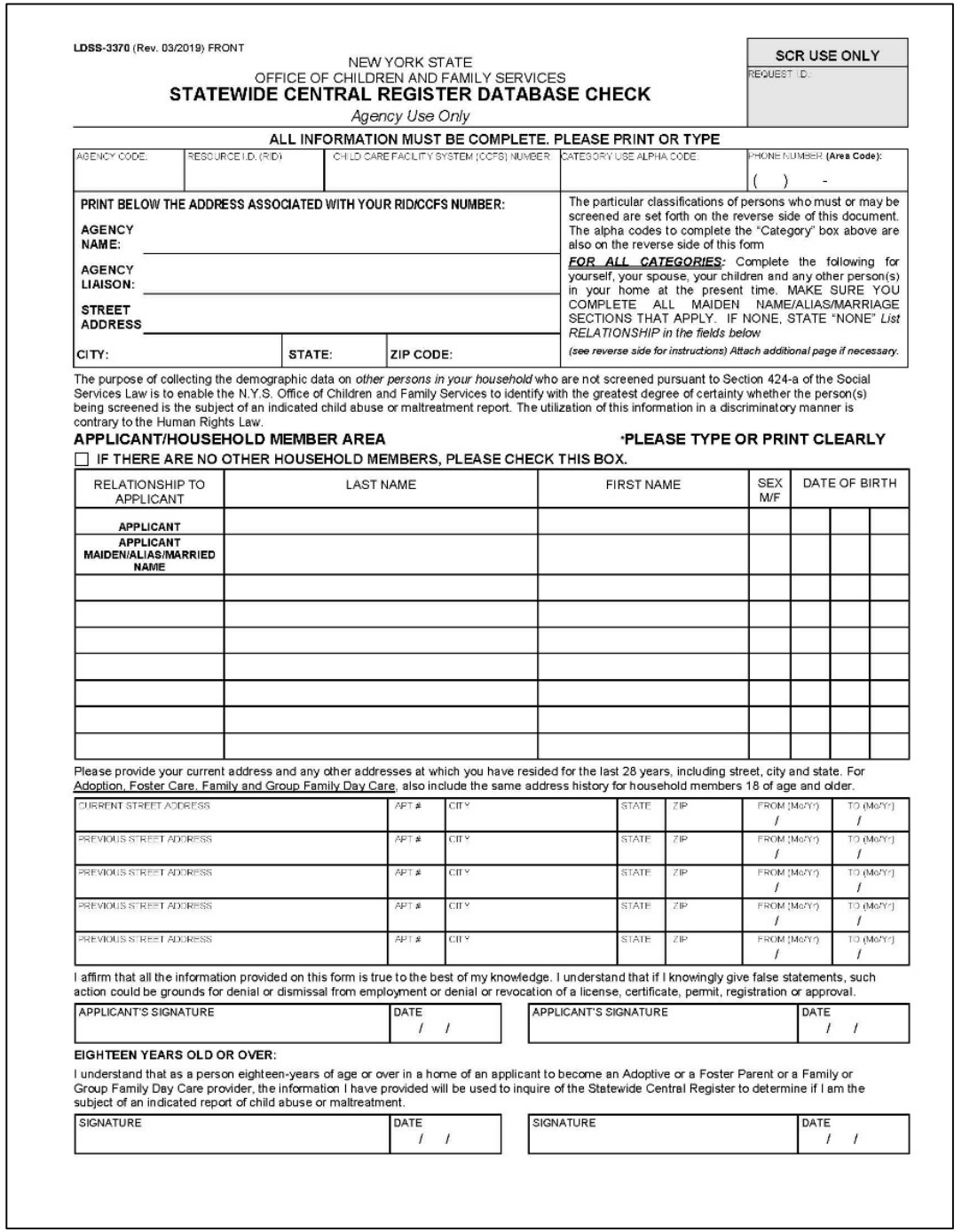
I _____ (Print Name), certify under penalty of perjury that the above information is complete and accurate.

_____ Mo / Day / Yr
Signature of Children's Camp Director

DOH-2271 (3/06)

NYS DOH 3370

- DO NOT SEND THIS FORM TO NYS!!!!
- This must be completed and signed by the Camp Director.
- This must include everyone currently living in the same household as the Camp Director.
- This must include the current address and all other addresses that the Camp Director resided at from 1992.
- It can take up to 2 weeks for a clearance letter from the State.
- The permit will not be issued without NYS clearance letter
- The form MUST BE LEGIBLE.



LDSS-3370 (Rev. 03/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
				( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA **·PLEASE TYPE OR PRINT CLEARLY**

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
APPLICANT MAIDEN/ALIAS/MARRIED NAME				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /	APPLICANT'S SIGNATURE	DATE / /

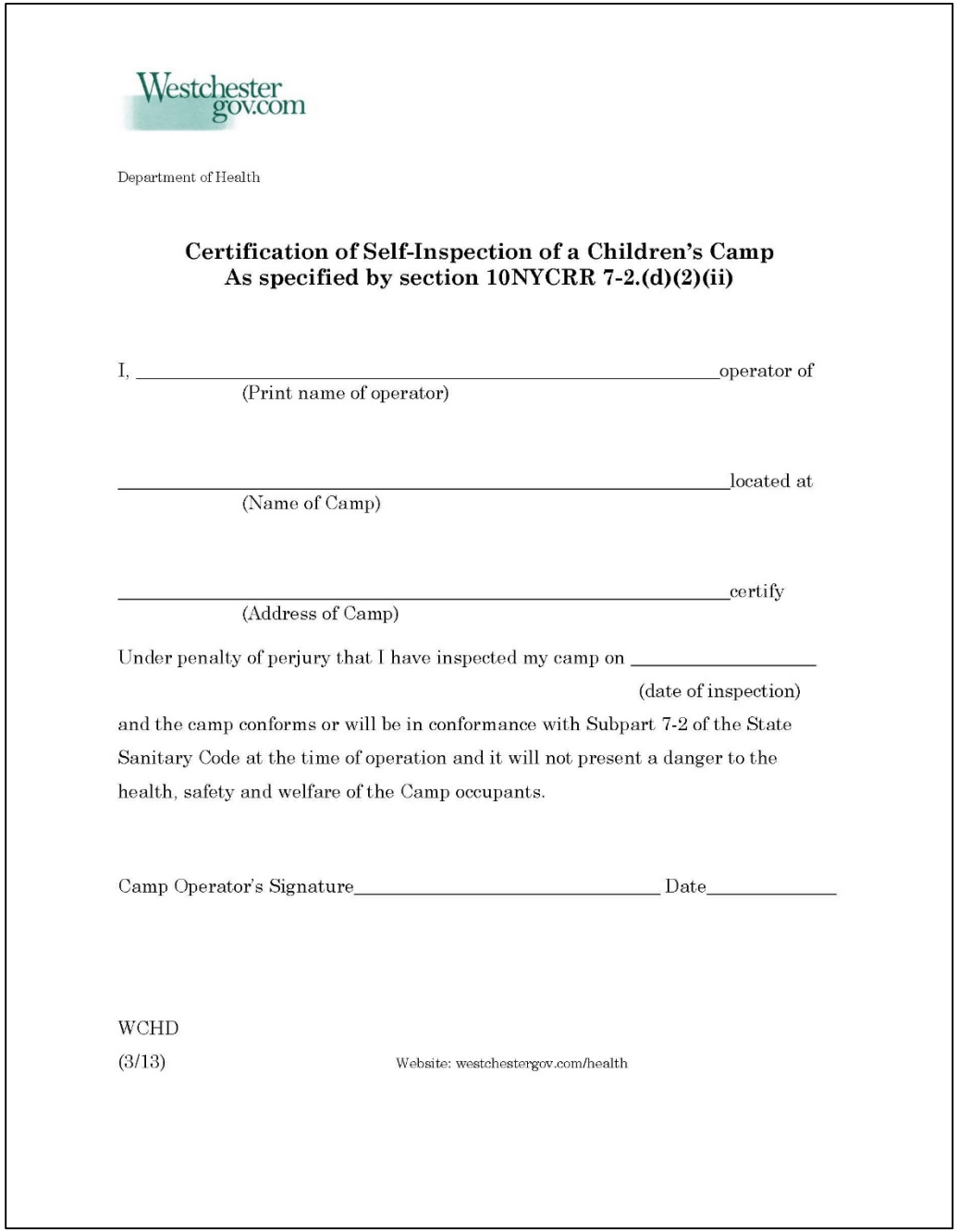
EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen-years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /	SIGNATURE	DATE / /

Camp Director's Self-Inspection

- This is required for every camp.
- Must use NYSDOH Form -1315, this form must be signed and retained on site for inspection.
- This is used to identify any areas of concern for health and safety for the campers and



Westchester gov.com

Department of Health

Certification of Self-Inspection of a Children's Camp
As specified by section 10NYCRR 7-2.(d)(2)(ii)

I, _____ operator of
(Print name of operator)

_____ located at
(Name of Camp)

_____ certify
(Address of Camp)

Under penalty of perjury that I have inspected my camp on _____
(date of inspection)
and the camp conforms or will be in conformance with Subpart 7-2 of the State Sanitary Code at the time of operation and it will not present a danger to the health, safety and welfare of the Camp occupants.

Camp Operator's Signature_____ Date_____

WCHD
(3/13)

Website: westchestergov.com/health

Amusement Device Survey

- This must be completed whether you have a regulated device or not.

Children's Camps
Amusement Device Survey

Complete this survey for each amusement device at your children's camp. Amusement devices are defined in Part 45 of the Department of Labor (DOL) regulations and include: carnival rides; go-carts; bumper boats; water slides (with a vertical drop of 20 feet or more); climbing walls with mechanical belays; challenge courses; zip lines; and giant swings. **Please return the survey by May 1, 2016 via mail or fax to WCHD-BPHP, Mount Kisco Central Office, 25 Moore Avenue, Mount Kisco, NY 10549 / FAX: 914-813-4281.**

Camp Name: _____ **County:** WESTCHESTER

☐ **No amusement devices available at the camp.**

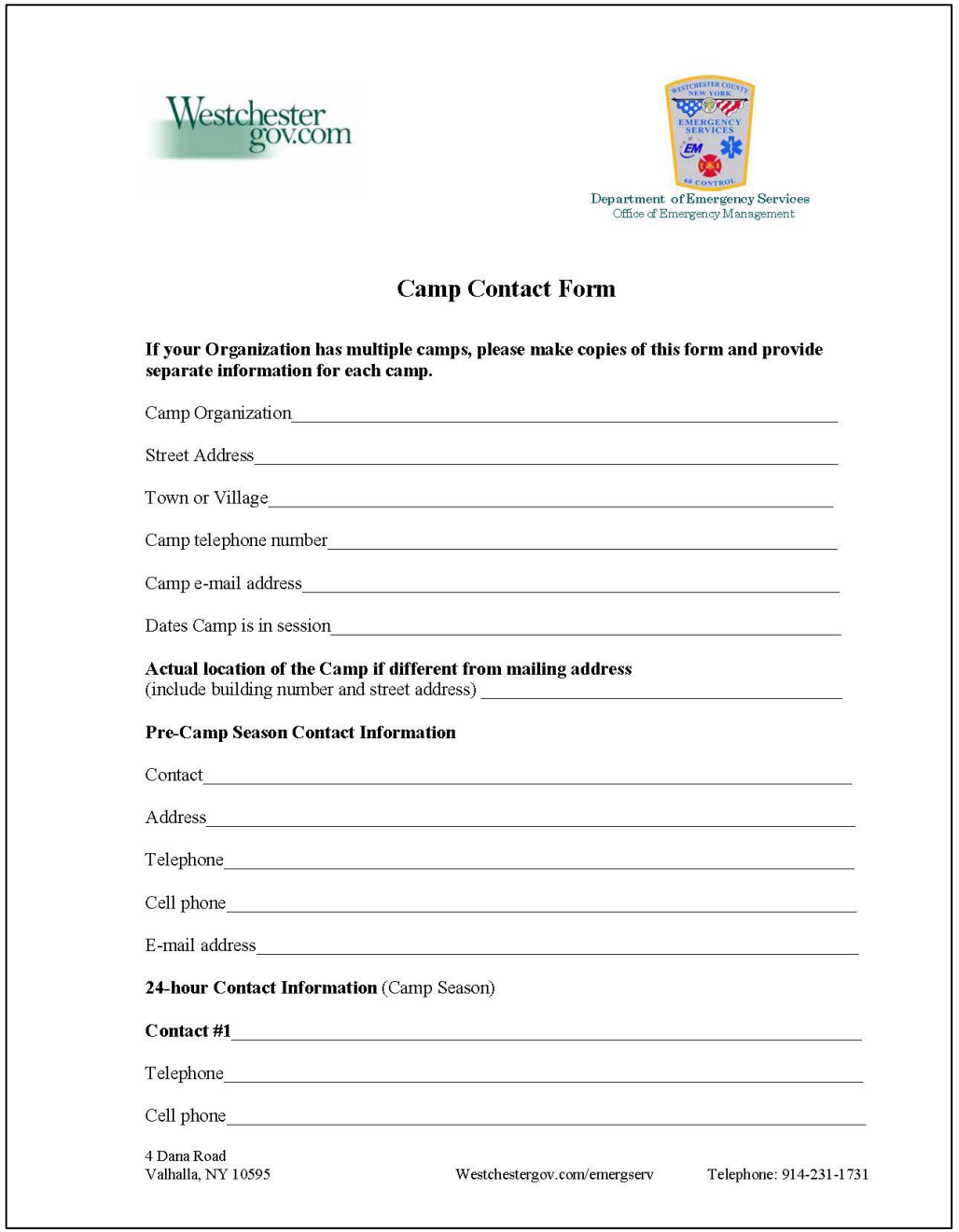
Amusement Device Type/Name List rope or challenge course elements separately. For devices other than challenge courses elements which are constructed on-site, provide the product manufacturer and serial number.	**Number Available**	**Amount of Liability Insurance Coverage**	**DOL Permit (Yes/No)**

Name of Person Completing Form: _____ **Telephone Number**: _____

P:\Sections\Community Health\CAMPS\Amusement devices\Amusement Device Survey.doc

Camp Contact Form

- MUST BE COMPLETED
- All the information provided is retained for contact information and emergency purposes.
- Two 24 hour contacts MUST BE PROVIDED.



Westchestergov.com

Department of Emergency Services
Office of Emergency Management

Camp Contact Form

If your Organization has multiple camps, please make copies of this form and provide separate information for each camp.

Camp Organization_____

Street Address_____

Town or Village_____

Camp telephone number_____

Camp e-mail address_____

Dates Camp is in session_____

Actual location of the Camp if different from mailing address
(include building number and street address) _____

Pre-Camp Season Contact Information

Contact_____

Address_____

Telephone_____

Cell phone_____

E-mail address_____

24-hour Contact Information (Camp Season)

Contact #1_____

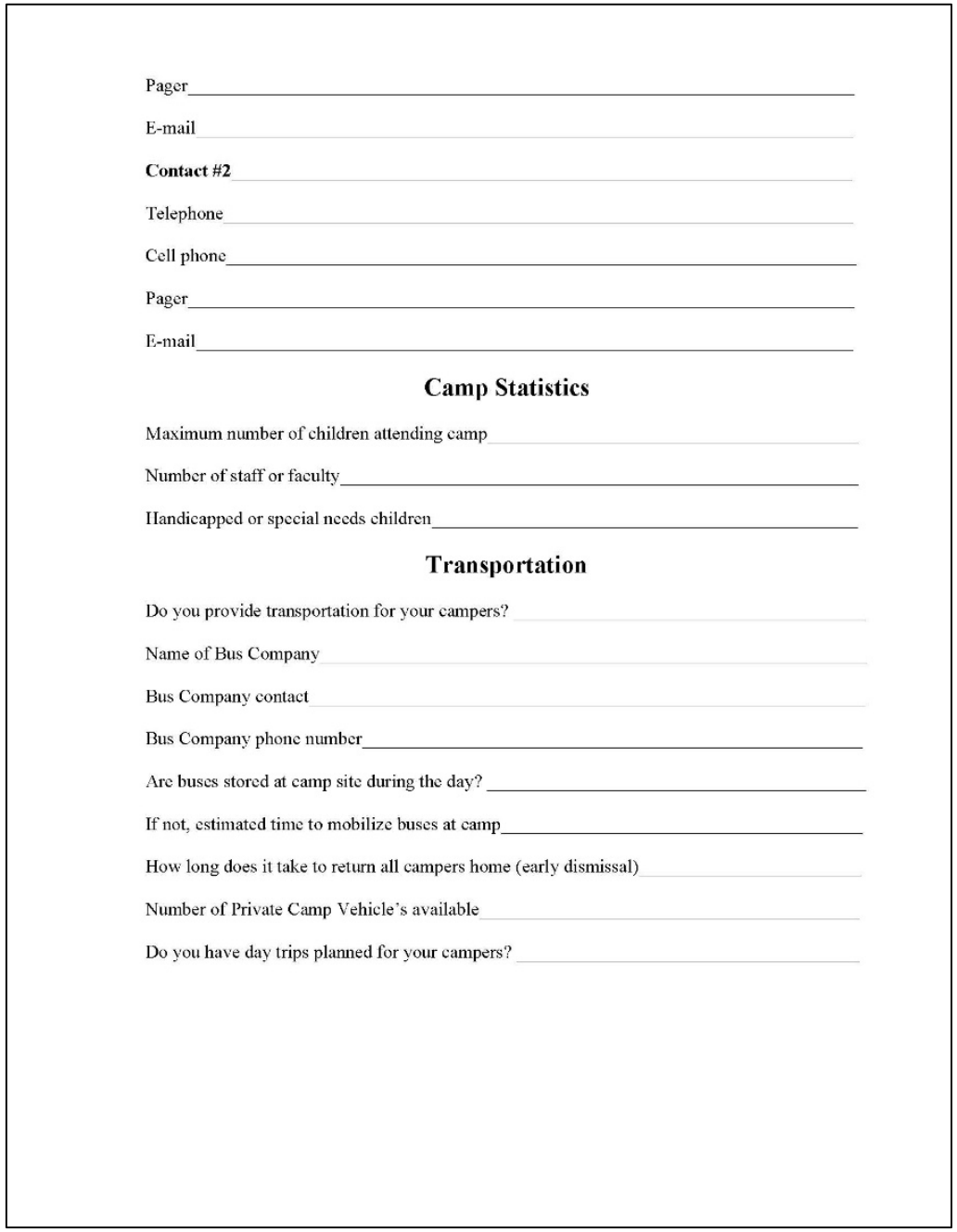
Telephone_____

Cell phone_____

4 Dana Road
Valhalla, NY 10595 Westchestergov.com/emergserv Telephone: 914-231-1731

Camp Contact Form Continued

- This form MUST BE COMPLETED.
- All the information provided is retained for contact information and emergency purposes.
- Two 24 hour contacts MUST BE PROVIDED.
- Maximum number of campers and staff.
- If you use a bus, the vendors information MUST BE PROVIDED.



Pager_____

E-mail_____

Contact #2_____

Telephone_____

Cell phone_____

Pager_____

E-mail_____

Camp Statistics

Maximum number of children attending camp_____

Number of staff or faculty_____

Handicapped or special needs children_____

Transportation

Do you provide transportation for your campers?_____

Name of Bus Company_____

Bus Company contact_____

Bus Company phone number_____

Are buses stored at camp site during the day?_____

If not, estimated time to mobilize buses at camp_____

How long does it take to return all campers home (early dismissal)_____

Number of Private Camp Vehicle's available_____

Do you have day trips planned for your campers?_____

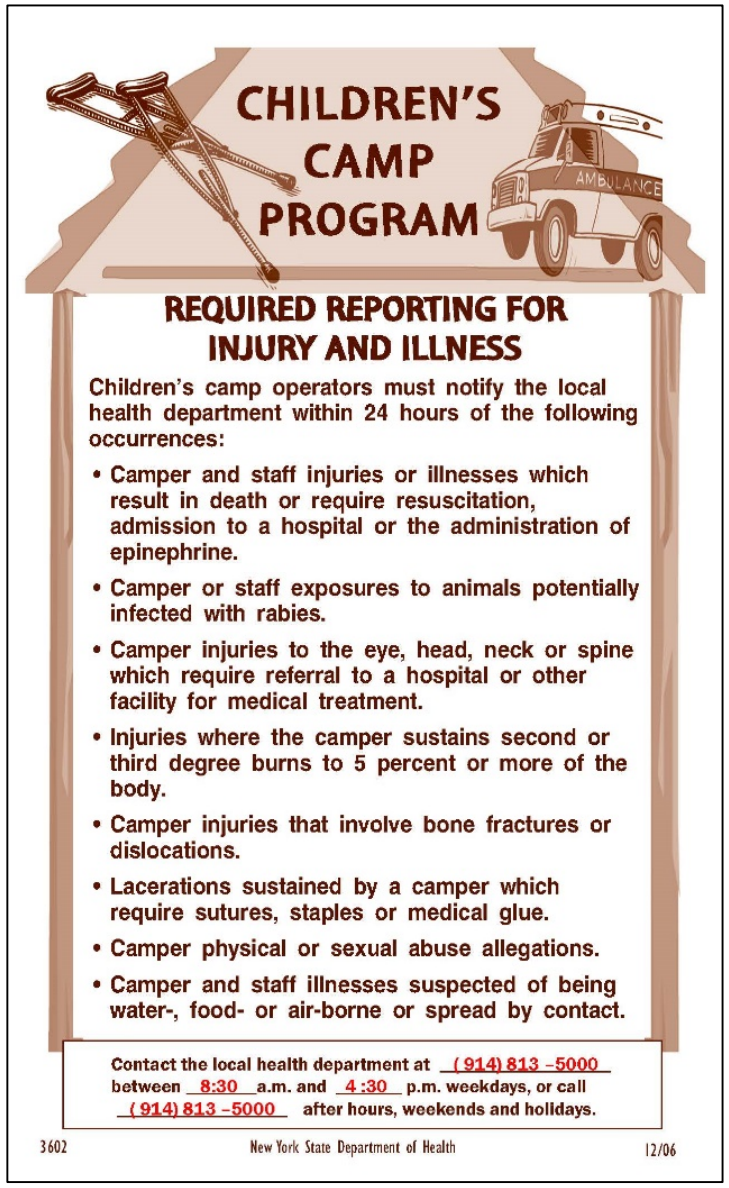
DO'S

- Review the Certification fact sheets immediately.
- Contact instructors for certifications in advance.
- Ask questions if you are unsure of something.
- Only submit the required forms.
- Submit Safety Plan trip appendix for approval.

DON'TS

- Do not submit an incomplete renewal package.
- Do not leave required information blank.
- Do not submit additional paperwork unless required by inspector.
- Do not submit copies of certifications unless asked by the inspector.
- Do not wait until the week before camp to submit this package.
- Do not submit blank injury reports with renewal application.

Reportable Injuries and Illness



CHILDREN'S CAMP PROGRAM

AMBULANCE

REQUIRED REPORTING FOR INJURY AND ILLNESS

Children's camp operators must notify the local health department within 24 hours of the following occurrences:

- Camper and staff injuries or illnesses which result in death or require resuscitation, admission to a hospital or the administration of epinephrine.
- Camper or staff exposures to animals potentially infected with rabies.
- Camper injuries to the eye, head, neck or spine which require referral to a hospital or other facility for medical treatment.
- Injuries where the camper sustains second or third degree burns to 5 percent or more of the body.
- Camper injuries that involve bone fractures or dislocations.
- Lacerations sustained by a camper which require sutures, staples or medical glue.
- Camper physical or sexual abuse allegations.
- Camper and staff illnesses suspected of being water-, food- or air-borne or spread by contact.

Contact the local health department at (914) 813 -5000 between 8:30 a.m. and 4 :30 p.m. weekdays, or call (914) 813 -5000 after hours, weekends and holidays.

3602 New York State Department of Health 12/06

New York State Sanitary Code Chapter 1

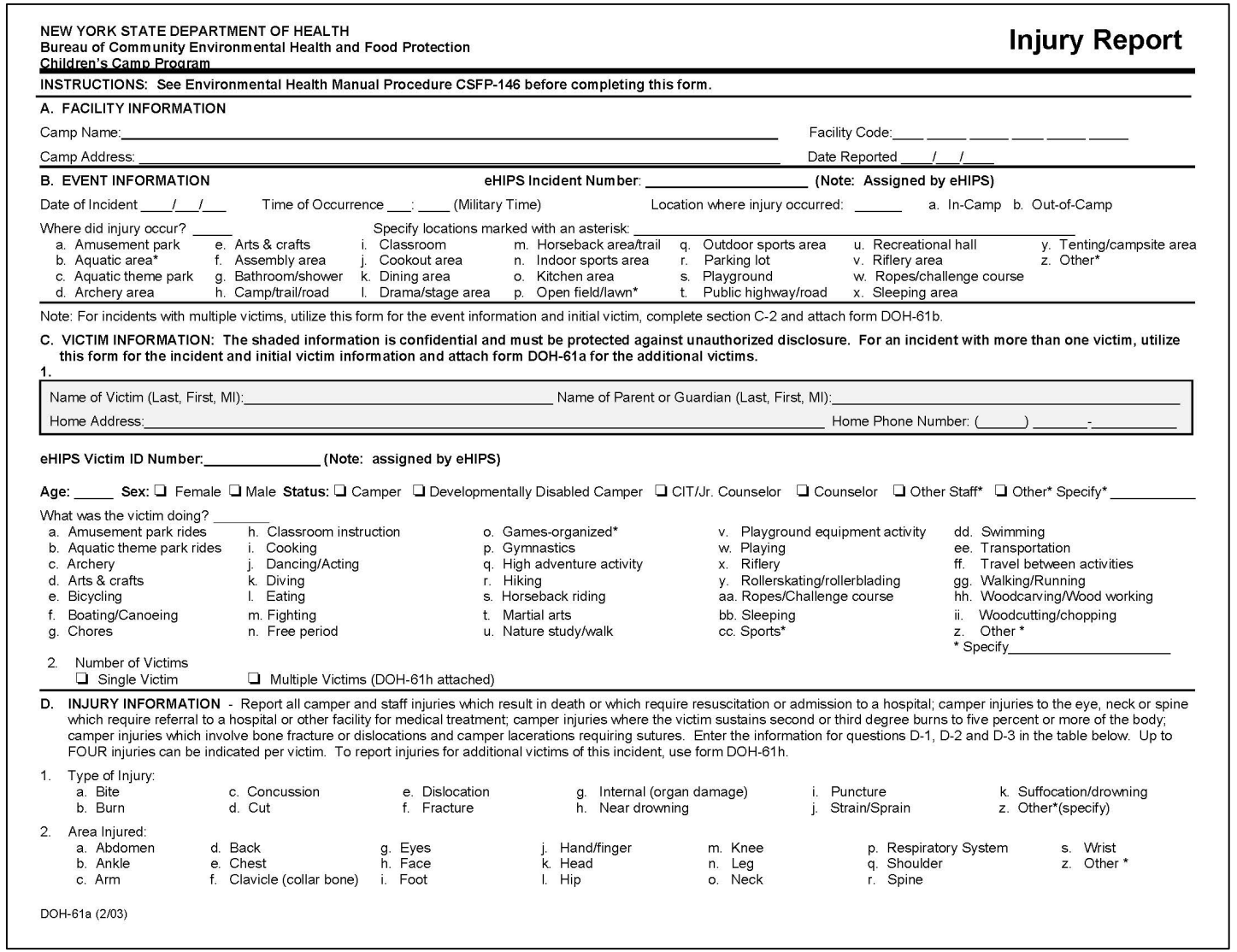
Subpart 7-2.8(d) requires that:

The following injuries, illnesses, and incidents to campers and/or staff members are to be reported to the Department of Health within 24 hours (including evenings, weekends, and holidays).

Campers	Staff
Reportable Illnesses/Injuries	Reportable Illnesses/Injuries
1. Resuscitations (i.e. use of CPR)	1. Resuscitations (i.e. use of CPR)
2. **Admissions** to hospitals	2. **Admissions** to hospitals
3. All illnesses suspected of being water, food, or air-borne or spread by contact	3. All illnesses suspected of being water, food, or air-borne or spread by contact
4. Deaths	4. Deaths
5. Administration of epinephrine (i.e., Epi-pen) as a result of illness or injury	5. Administration of epinephrine (i.e., Epi-pen) as a result of illness or injury
6. Exposure to animal potentially infected with rabies.	6. Exposure to animal potentially infected with rabies.
7. **Referrals** for medical treatment of a hospital or other medical facility for: **eye**, **head**, **neck**, or **spine** injuries.	7. Not applicable for Staff
8. Second or third degree burns to 5% or more of the body.	8. Not applicable for Staff
9. Bone fractures and dislocations	9. Not applicable for Staff
10. Stitches	10. Not applicable for Staff
11. **Allegations** of physical or sexual abuse.	11. Not applicable for Staff

Injury Report Form

- Reporting Phone Number (914)-864-7330
- 24 HOUR HOTLINE (914)-813-5000
- Reporting Fax Number (914)-813-4281
- ALL SECTIONS MUST BE ANSWERED AND A NARRATIVE OF THE INCIDENT MUST BE INCLUDED.



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

Injury Report

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.

A. FACILITY INFORMATION

Camp Name:_____ Facility Code:____ ____ ____ ____ ____ ____

Camp Address: _____ Date Reported ____/___/____

B. EVENT INFORMATION **eHIPS Incident Number: _____ (Note: Assigned by eHIPS)**

Date of Incident ____/___/___ Time of Occurrence ___: ____ (Military Time) Location where injury occurred: _____ a. In-Camp b. Out-of-Camp

Where did injury occur? _____ Specify locations marked with an asterisk: _____

a. Amusement park	e. Arts & crafts	i. Classroom	m. Horseback area/trail	q. Outdoor sports area	u. Recreational hall	y. Tenting/campsite area
b. Aquatic area*	f. Assembly area	j. Cookout area	n. Indoor sports area	r. Parking lot	v. Riflery area	z. Other*
c. Aquatic theme park	g. Bathroom/shower	k. Dining area	o. Kitchen area	s. Playground	w. Ropes/challenge course	
d. Archery area	h. Camp/trail/road	l. Drama/stage area	p. Open field/lawn*	t. Public highway/road	x. Sleeping area	

Note: For incidents with multiple victims, utilize this form for the event information and initial victim, complete section C-2 and attach form DOH-61b.

C. VICTIM INFORMATION: The shaded information is confidential and must be protected against unauthorized disclosure. For an incident with more than one victim, utilize this form for the incident and initial victim information and attach form DOH-61a for the additional victims.

1.

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

Home Address:_____ Home Phone Number: (_____) _____-_____

eHIPS Victim ID Number:_____ (Note: assigned by eHIPS)

Age: _____ **Sex:** ❑ Female ❑ Male **Status:** ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor ❑ Other Staff* ❑ Other* Specify* _____

What was the victim doing? _____

a. Amusement park rides	h. Classroom instruction	o. Games-organized*	v. Playground equipment activity	dd. Swimming
b. Aquatic theme park rides	i. Cooking	p. Gymnastics	w. Playing	ee. Transportation
c. Archery	j. Dancing/Acting	q. High adventure activity	x. Riflery	ff. Travel between activities
d. Arts & crafts	k. Diving	r. Hiking	y. Rollerskating/rollerblading	gg. Walking/Running
e. Bicycling	l. Eating	s. Horseback riding	aa. Ropes/Challenge course	hh. Woodcarving/Wood working
f. Boating/Canoeing	m. Fighting	t. Martial arts	bb. Sleeping	ii. Woodcutting/chopping
g. Chores	n. Free period	u. Nature study/walk	cc. Sports*	z. Other *
				* Specify_____

2. Number of Victims
❑ Single Victim ❑ Multiple Victims (DOH-61h attached)

D. INJURY INFORMATION - Report all camper and staff injuries which result in death or which require resuscitation or admission to a hospital; camper injuries to the eye, neck or spine which require referral to a hospital or other facility for medical treatment; camper injuries where the victim sustains second or third degree burns to five percent or more of the body; camper injuries which involve bone fracture or dislocations and camper lacerations requiring sutures. Enter the information for questions D-1, D-2 and D-3 in the table below. Up to FOUR injuries can be indicated per victim. To report injuries for additional victims of this incident, use form DOH-61h.

1. Type of Injury:

a. Bite	c. Concussion	e. Dislocation	g. Internal (organ damage)	i. Puncture	k. Suffocation/drowning
b. Burn	d. Cut	f. Fracture	h. Near drowning	j. Strain/Sprain	z. Other*(specify)

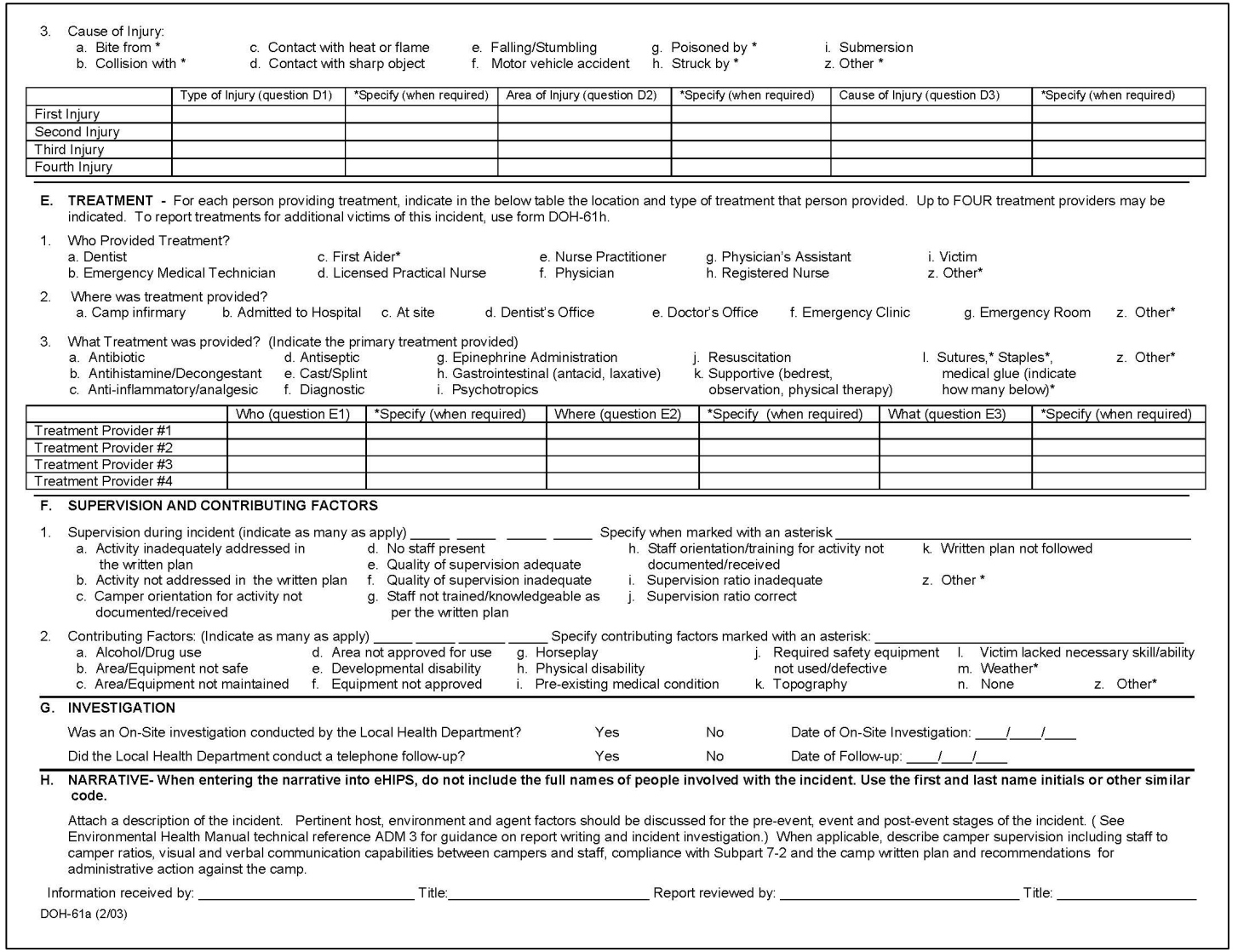
2. Area Injured:

a. Abdomen	d. Back	g. Eyes	j. Hand/finger	m. Knee	p. Respiratory System	s. Wrist
b. Ankle	e. Chest	h. Face	k. Head	n. Leg	q. Shoulder	z. Other *
c. Arm	f. Clavicle (collar bone)	i. Foot	l. Hip	o. Neck	r. Spine	

DOH-61a (2/03)

Injury Report Form

- **All sections must be answered.**
- If multiple injuries were sustained, complete each box for question 3.
- If treatment was received from multiple providers, list each provider and what was performed.
- The number of sutures or staples used MUST BE INCLUDED.
- Supervision and contributing factors cannot always be “adequate supervision, ratios correct, none or other”.



3. Cause of Injury:
   a. Bite from * b. Collision with * c. Contact with heat or flame d. Contact with sharp object e. Falling/Stumbling f. Motor vehicle accident g. Poisoned by * h. Struck by * i. Submersion z. Other *

	Type of Injury (question D1)	*Specify (when required)	Area of Injury (question D2)	*Specify (when required)	Cause of Injury (question D3)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

E. TREATMENT - For each person providing treatment, indicate in the below table the location and type of treatment that person provided. Up to FOUR treatment providers may be indicated. To report treatments for additional victims of this incident, use form DOH-61h.

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. 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 the primary treatment provided)
   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. SUPERVISION AND CONTRIBUTING FACTORS

1. Supervision during incident (indicate as many as apply) _____ _____ _____ _____ Specify when marked with an asterisk _____
   a. Activity inadequately addressed in the written plan b. Activity not addressed in the written plan c. Camper orientation for activity not documented/received d. No staff present e. Quality of supervision adequate f. Quality of supervision inadequate g. Staff not trained/knowledgeable as per the written plan h. Staff orientation/training for activity not documented/received i. Supervision ratio inadequate j. Supervision ratio correct k. Written plan not followed z. Other *
2. Contributing Factors: (Indicate as many as apply) _____ _____ _____ _____ Specify contributing factors marked with an asterisk: _____
   a. Alcohol/Drug use b. Area/Equipment not safe c. Area/Equipment not maintained d. Area not approved for use e. Developmental disability f. Equipment not approved g. Horseplay h. Physical disability i. Pre-existing medical condition j. Required safety equipment not used/defective k. Topography l. Victim lacked necessary skill/ability m. Weather* n. None z. Other*

G. 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: ____/____/____

H. 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.

Attach a description of the incident. Pertinent host, environment and agent factors should be discussed for the pre-event, event and post-event stages of the incident. (See Environmental Health Manual technical reference ADM 3 for guidance on report writing and incident investigation.) When applicable, describe camper supervision including staff to camper ratios, visual and verbal communication capabilities between campers and staff, compliance with Subpart 7-2 and the camp written plan and recommendations for administrative action against the camp.

Information received by: _____ Title: _____ Report reviewed by: _____ Title: _____

DOH-61a (2/03)

Multiple Victim Injury Report Form

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

Multiple Victim Injury Report Form

Instruction: See Environmental Health Manual Procedure CSFP 146 and back of form prior to completing

Camp Name: _____ **eHIPS Incident Number:** _____
Address: _____ **Incident Date:** _____/_____/_____

VICTIM INFORMATION:

Name of Patient: _____
Home Address: _____
Name of Parent or Guardian _____
Home Phone Number (_____) _____ **Shaded information is confidential

Age (years): _____ Sex: ❑ Female ❑ Male **eHIPS Victim Number:** _____ (assigned by eHIPS)

Status: ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor
❑ Other Staff* _____ ❑ Other*(Specify) _____

1. What was the victim doing? _____ Other* (specify) _____

2. Injury:

	Injury Type (question 2a)	*Specify (when required)	Area Injured (question 2b)	*Specify (when required)	Cause of Injury (question 2c)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

3. Treatment:

	Who (question 3a)	*Specify (when required)	Where (question 3b)	*Specify (when required)	What (question 3c)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

VICTIM INFORMATION: **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____
Home Address: _____
Name of Parent or Guardian (Last, First, M.I.) _____
Home Phone Number (_____) _____ **Shaded information is confidential

Age: _____ Sex: ❑ Female ❑ Male

Status: ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor
❑ Other Staff* _____ ❑ Other*(Specify) _____

1. What was the victim doing? _____ Other* (specify) _____

2. Injury:

	Injury Type (question 2a)	*Specify (when required)	Area Injured (question 2b)	*Specify (when required)	Cause of Injury (question 2c)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

3. Treatment:

	Who (question 3a)	*Specify (when required)	Where (question 3b)	*Specify (when required)	What (question 3c)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

DOH-61h (2/03)

Instructions: Use this form as a continuation of the DOH-61 form to collect injury information for multiple victims whose injuries are associated with a single event (i.e. vehicle collision)

1. **What was victim doing?**

a. Amusement park rides	k. Dancing/acting	u. Martial Arts	ff. Travel between activities
b. Aquatic theme park rides	l. Diving	v. Nature study/walk	gg. Walking/running
c. Archery	m. Eating	w. Playground equipment activity	hh. Woodcarving/wood working
d. Arts & Crafts	n. Fighting	x. Playing	ii. Woodcutting/chopping
e. Bicycling	o. Free period	y. Riflery	z. Other*
e. Boating/Canoeing	p. Games – organized*	aa. Rollerskating/rollerblading	
f. Chores	q. Gymnastics	bb. Ropes/challenge course	
g. Classroom instruction	r. High adventure activity	cc. Sleeping	
h. Cooking	s. Hiking	dd. Swimming	
i. Court/Field sports*	t. Horseback riding	ee. Transportation	

2. **Injury** - Report all camper and staff injuries which result in death or which require resuscitation or admission to a hospital; camper injuries to the eye, neck or spine which require referral to a hospital or other facility for medical treatment; camper injuries where the victim sustains second or third degree burns to five percent or more of the body; camper injuries which involve bone fracture or dislocations and camper lacerations requiring sutures. Enter the information for questions 2A, 2B, and 2C in the table on front page. Up to FOUR injuries can be indicated per victim.

A. Type of Injury:

a. Bite	d. Cut	g. Internal (organ damage)	j. Strain/Sprain
b. Burn	e. Dislocation	h. Near Drowning	k. Suffocation/Drowning
c. Concussion	f. Fracture	i. Puncture	z. Other*

B. Area Injured:

a. Abdomen	e. Chest	i. Foot	m. Knee	q. Shoulder
b. Ankle	f. Clavicle (collar bone)	j. Hand/Finger	n. Leg	r. Spine
c. Arm	g. Eyes	k. Head	o. Neck	s. Wrist
d. Back	h. Face	l. Hip	p. Respiratory System	z. Other *

C. Cause of Injury:

a. Bite from *	c. Contact with heat or flame	e. Falling/Stumbling	g. Poisoned by *	i. Submersion
b. Collision with *	d. Contact with sharp object	f. Motor vehicle accident	h. Struck by *	z. Other *

3. **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. Enter the information for questions 3A, 3B, 3C in the table on the opposite page.

A. Who Provided Treatment?

a. Dentist	c. First Aider*	e. Nurse Practitioner	g. Physician's Assistant	i. Victim
b. Emergency Medical Technician	d. Licensed Practical Nurse	f. Physician	h. Registered Nurse	z. Other*

B. Where was treatment provided?

a. At camp infirmary	c. At site	e. Doctor's Office	g. Emergency Room
b. Admitted to Hospital	d. Dentist's Office	f. Emergency Clinic	z. Other*

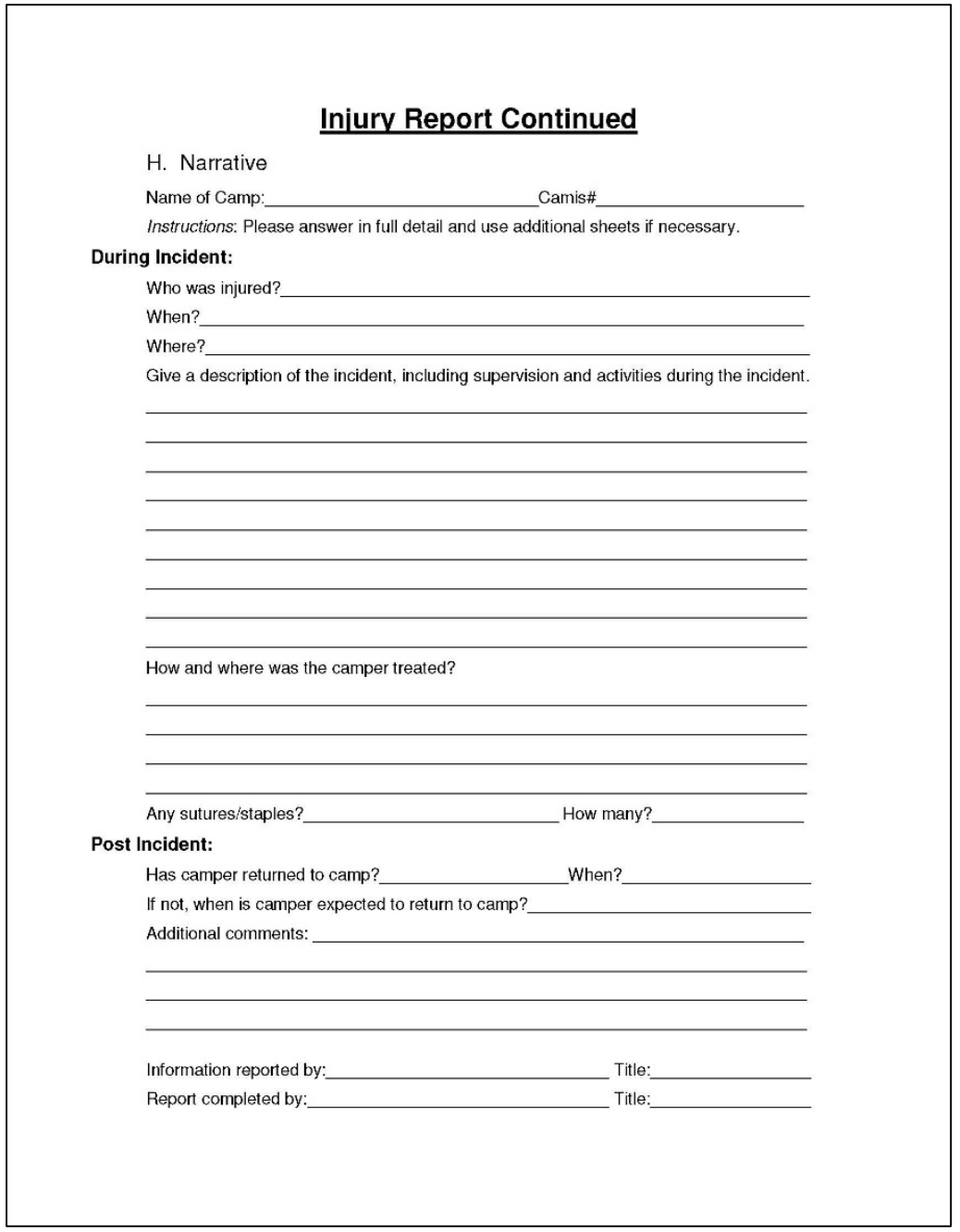
C. What Treatment was provided?

a. Antibiotic	f. Diagnostic	k. Supportive (bedrest, observation, physical therapy)
b. Antihistamine/Decongestant	g. Epinephrine Administration	l. Sutures*, Staples*, medical glue (*Specify how many in table on front)
c. Anti-inflammatory/analgesic	h. Gastrointestinal (antacid, laxative)	
d. Antiseptic	i. Psychotropics	z. Other*
e. Cast/Splint	j. Resuscitation	

DOH-61h (2/03)

Injury Report Narrative

- Narrative form must be completed and submitted for ALL injuries.
- Use this form for single and multiple victim injury reports.



Injury Report Continued

H. Narrative

Name of Camp:_____Camis#_____

Instructions: Please answer in full detail and use additional sheets if necessary.

During Incident:

Who was injured?_____

When?_____

Where?_____

Give a description of the incident, including supervision and activities during the incident.

_____

_____

_____

_____

_____

_____

_____

_____

_____

How and where was the camper treated?

_____

_____

_____

_____

Any sutures/staples?_____ How many?_____

Post Incident:

Has camper returned to camp?_____When?_____

If not, when is camper expected to return to camp?_____

Additional comments: _____

_____

_____

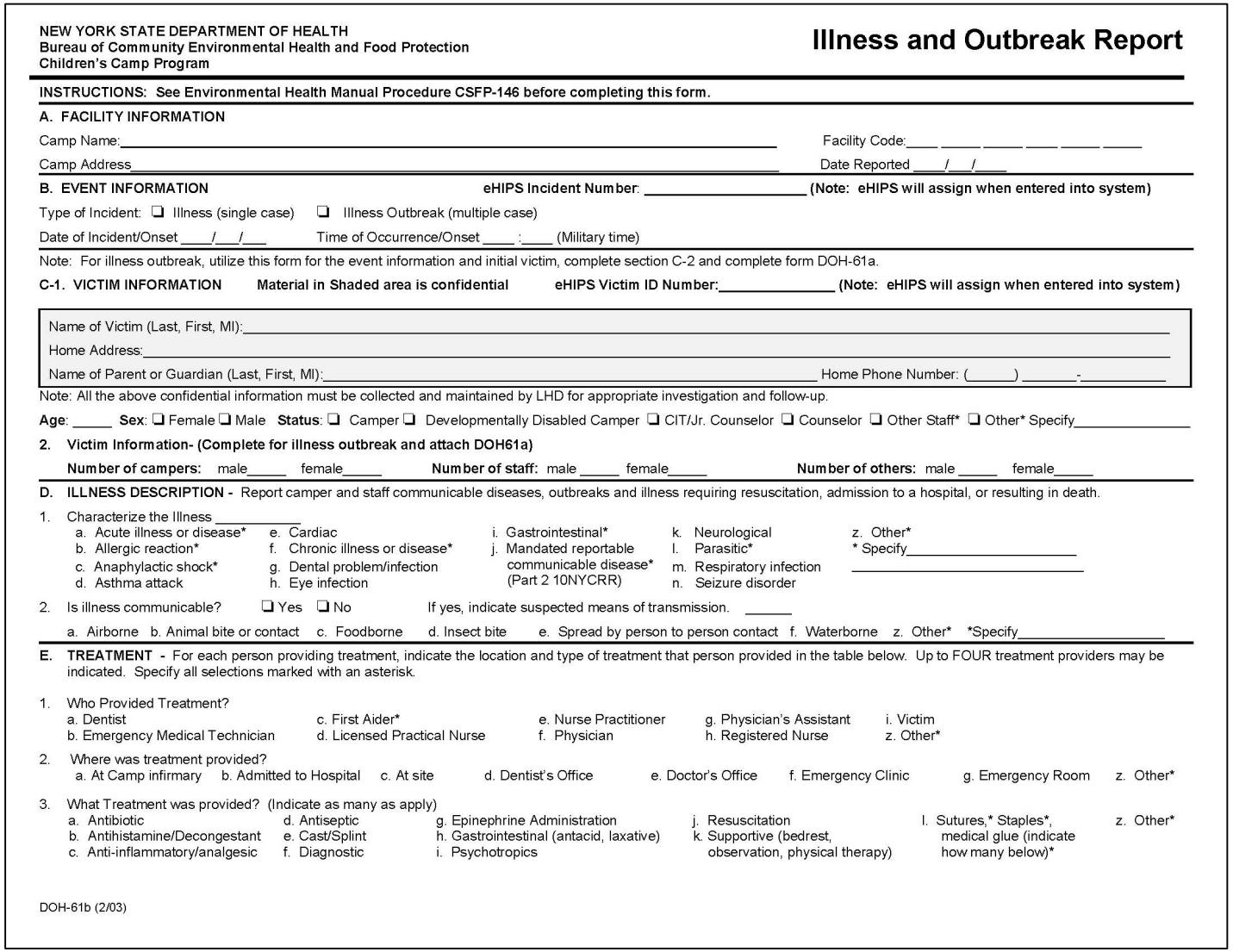
_____

Information reported by:_____ Title:_____

Report completed by:_____ Title:_____

Illness and Outbreak Report Form

- The entire form must be completed.
- An outbreak is considered more than 1 case of certain diseases.
- Reporting Phone Number: (914)-864-7330
- 24 HOUR HOTLINE (914) 813-5000
- Reporting Fax Number: (914)-813-4281



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

Illness and Outbreak Report

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.

A. FACILITY INFORMATION

Camp Name:_____ Facility Code:____ ____ ____ ____ ____ ____

Camp Address_____ Date Reported ____/___/____

B. EVENT INFORMATION **eHIPS Incident Number:** _____ **(Note: eHIPS will assign when entered into system)**

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-61a.

C-1. VICTIM INFORMATION **Material in Shaded area is confidential** **eHIPS Victim ID Number:**_____ **(Note: eHIPS will assign when entered into system)**

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

Home Address:_____

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

Note: All the above confidential information must be collected and maintained by LHD for appropriate investigation and follow-up.

Age: _____ **Sex**: ❑ Female ❑ Male **Status**: ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor ❑ Other Staff* ❑ Other* Specify_____

2. Victim Information- (Complete for illness outbreak and attach DOH61a)

Number of campers: male_____ female_____ **Number of staff:** male _____ female_____ **Number of others:** male _____ female_____

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*

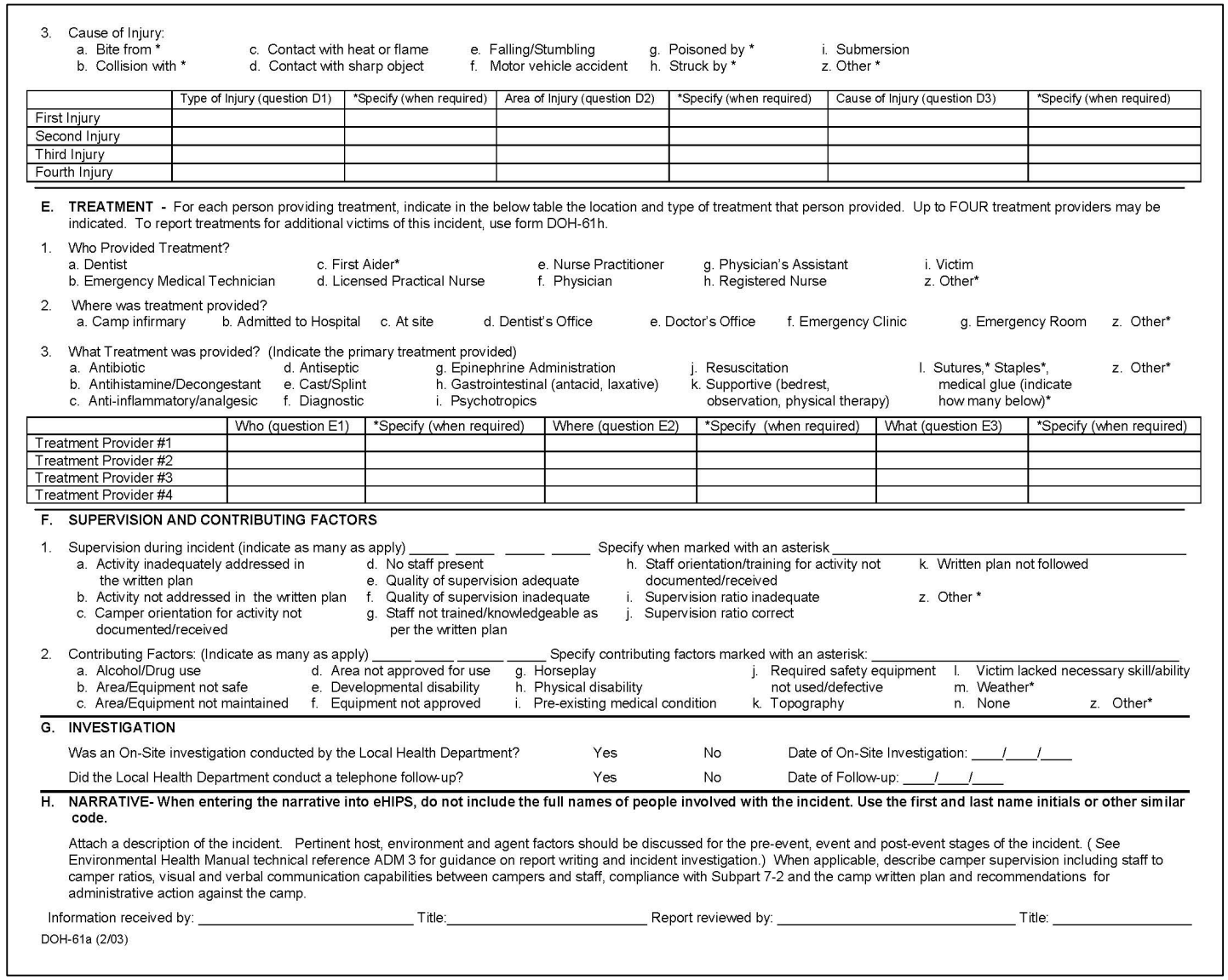
3. What Treatment was provided? (Indicate as many as apply)

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*

DOH-61b (2/03)

Illness Outbreak Form Continued

- The entire form must be completed.
- An outbreak is considered more than 1 case of certain diseases.
- Reporting Phone Number: (914)-864-7330
- 24 HOUR HOTLINE (914) 813-5000
- Reporting Fax Number: (914)-813-4281



3. Cause of Injury:
   a. Bite from * c. Contact with heat or flame e. Falling/Stumbling g. Poisoned by * i. Submersion
   b. Collision with * d. Contact with sharp object f. Motor vehicle accident h. Struck by * z. Other *

	Type of Injury (question D1)	*Specify (when required)	Area of Injury (question D2)	*Specify (when required)	Cause of Injury (question D3)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

E. TREATMENT - For each person providing treatment, indicate in the below table the location and type of treatment that person provided. Up to FOUR treatment providers may be indicated. To report treatments for additional victims of this incident, use form DOH-61h.

1. Who Provided Treatment?
   a. Dentist c. First Aider* e. Nurse Practitioner g. Physician's Assistant i. Victim
   b. Emergency Medical Technician d. Licensed Practical Nurse f. Physician h. Registered Nurse z. Other*

2. Where was treatment provided?
   a. 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 the primary treatment provided)
   a. Antibiotic d. Antiseptic g. Epinephrine Administration j. Resuscitation l. Sutures,* Staples*, z. Other*
   b. Antihistamine/Decongestant e. Cast/Splint h. Gastrointestinal (antacid, laxative) k. Supportive (bedrest, observation, physical therapy) medical glue (indicate how many below)*
   c. Anti-inflammatory/analgesic f. Diagnostic i. Psychotropics

	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. SUPERVISION AND CONTRIBUTING FACTORS

1. Supervision during incident (indicate as many as apply) ____ ____ ____ ____ Specify when marked with an asterisk ____
   a. Activity inadequately addressed in the written plan d. No staff present h. Staff orientation/training for activity not documented/received k. Written plan not followed
   b. Activity not addressed in the written plan e. Quality of supervision adequate i. Supervision ratio inadequate z. Other *
   c. Camper orientation for activity not documented/received f. Quality of supervision inadequate j. Supervision ratio correct
   g. Staff not trained/knowledgeable as per the written plan

2. Contributing Factors: (Indicate as many as apply) ____ ____ ____ ____ Specify contributing factors marked with an asterisk: ____
   a. Alcohol/Drug use d. Area not approved for use g. Horseplay j. Required safety equipment not used/defective l. Victim lacked necessary skill/ability
   b. Area/Equipment not safe e. Developmental disability h. Physical disability m. Weather*
   c. Area/Equipment not maintained f. Equipment not approved i. Pre-existing medical condition k. Topography n. None z. Other*

G. 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: ____/____/____

H. 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.

Attach a description of the incident. Pertinent host, environment and agent factors should be discussed for the pre-event, event and post-event stages of the incident. (See Environmental Health Manual technical reference ADM 3 for guidance on report writing and incident investigation.) When applicable, describe camper supervision including staff to camper ratios, visual and verbal communication capabilities between campers and staff, compliance with Subpart 7-2 and the camp written plan and recommendations for administrative action against the camp.

Information received by: ____ Title: ____ Report reviewed by: ____ Title: ____

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For More Information

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