Illness and Outbreak Report

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.										
A. FACILITY INFORMATION										
Ca	np Name: Facility Code: Facility Code:									
Cai	np Address Date Reported//_									
В.	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* e. Cardiac i. Gastrointestinal* k. Neurological z. Other* b. Allergic reaction* f. Chronic illness or disease* j. Mandated reportable l. Parasitic* * Specify c. Anaphylactic shock* g. Dental problem/infection communicable disease* m. Respiratory infection									
_	d. Asthma attack h. Eye infection (Part 2 10NYCRR) n. Seizure disorder									
2.	Is illness communicable?									
_	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 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. 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 d. Antiseptic g. Epinephrine Administration j. Resuscitation j. Resuscitation l. Sutures,* Staples*, z. Other* b. Antihistamine/Decongestant c. Anti-inflammatory/analgesic f. Diagnostic i. Psychotropics k. Supportive (bedrest, observation, physical therapy) how many below)*									

		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	a description of the illness. Include details of onset, treatment and resolution (returned to camp or went home). For foodborne outbreak investigations, follow Environmental Manual Procedure 803 in addition to completing this report.							
	Health Manual Procedur	e 603 in addition to con	ipleting this report.						
Information received by:			Title:						
Report reviewed by:			Title:						