

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

Was the camp emergency care provider notified of the incident? 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 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.

