

Multiple Victim Injury Report Form

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

Camp Name: _____
 Address: _____

eHIPS Incident Number: _____
 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)

	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)

	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)

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First Injury						
Second Injury						
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Fourth Injury						

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	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						

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. Rifflery | 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 |
| c. Anti-inflammatory/analgesic | h. Gastrointestinal (antacid, laxative) | (*Specify how many in table on front) |
| d. Antiseptic | i. Psychotropics | z. Other* |
| e. Cast/Splint | j. Resuscitation | |