

ACCIDENT / INJURY / MEDICAL INCIDENT REPORT

CAMP NAME: _____ CAMP ADDRESS _____

NAME OF PERSON INVOLVED _____ DOB: _____

AGE _____ SEX _____ LAST CAMPER STAFF VISITOR FIRST MIDDLE INITIAL MONTH/DAY/YEAR

ADDRESS: _____ PHONE: _____

NAME OF PARENT / GUARDIAN _____ PHONE: _____

ADDRESS IF DIFFERENT: _____

NAME / ADDRESSES OF WITNESSES (MAY ATTACH SIGNED STATEMENTS)

1. _____
2. _____
3. _____

TYPE OF INCIDENT: BEHAVIORAL INJURY MEDICAL EPIDEMIC ILLNESS ERROR / OMISSION OTHER

DATE OF INCIDENT _____ HOUR _____ AM PM

DESCRIBE THE SEQUENCE OF EVENTS IN DETAIL THAT LED UP TO THIS INCIDENT, INCLUDING WHAT THE (INJURED/ILL) PERSON WAS DOING AT THE TIME:

WHERE DID THIS INCIDENT OCCUR? SPECIFY LOCATION OF ALL PERSONS INVOLVED. USE A DIAGRAM AS NECESSARY.

WAS THE INJURED/ILL PERSON PARTICIPATING IN AN ACTIVITY AT THE TIME OF THE INCIDENT? YES NO

IF SO WHAT ACTIVITY? _____

WAS ANY EQUIPMENT INVOLVED IN THE INCIDENT? SPECIFY _____

WHAT COULD HAVE BEEN DONE TO PREVENT THIS INCIDENT? _____

EMERGENCY PROCEDURES FOLLOWED AT THE TIME OF INCIDENT: _____

PERSONS INVOLVED IN EMERGENCY PROCEDURES: _____

MEDICAL REPORT OF INCIDENT

WHERE PARENTS / FAMILY NOTIFIED YES NO BY PHONE VOICEMAIL EMAIL WRITING OTHER
BY WHOM? _____ TITLE _____ TIME _____ DATE _____

PARENT RESPONSE _____

WHERE WAS TREATMENT GIVEN? (CHECK AND COMPLETE ALL THAT APPLY)

AT SITE OF INJURY: WHERE? _____ BY WHOM? _____
TREATMENT PROVIDED _____

CAMP HEALTH CENTER: BY WHOM? _____ TITLE _____
TREATMENT PROVIDED _____

PHYSICIAN OFFICE: BY WHOM? _____ TITLE _____
RELEASED TO: CAMP ACTIVITY CAMP HEALTH CENTER HOME EMS REFERRED TO ER

HOSPITAL: TREATED AND TRANSPORTED BY EMS TAKEN IN CAMP VEHICLE TO HOSPITAL
NAME AND ADDRESS OF HOSPITAL _____
DATE OF HOSPITAL VISIT _____ TREATED AND RELEASED ADMITTED
NAME OF ATTENDING PHYSICIAN _____ DATE RELEASED _____
RELEASED TO: CAMP - FULL ACTIVITY CAMP - LIMITED ACTIVITY CAMP HEALTH CENTER PARENTS
 DECEASED REFERRED TO SPECIALIST _____ OTHER

COMMENTS _____

PERSONS NOTIFIED (DIRECTORS, EMERGENCY CONTACTS, ETC)

NAME	POSITION	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

DESCRIBE ANY CONTACT MADE WITH THE MEDIA REGARDING THIS INCIDENT _____

THIS FORM COMPLETED BY (PRINT) _____		POSITION _____
SIGNED _____	DATE _____	TIME _____

INSURANCE NOTIFICATION / BILLED

PATIENT'S INSURANCE BY PARENT/PATIENT CAMP DATE _____
 CAMP INSURANCE _____
 WORKER'S COMPENSATION CLAIM # _____