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

Epinephrine Administration

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.

Instructions for completing the Children's Camp Epinephrine Administration Report

Local health department staff are responsible for completion of the form and submittal to the Bureau of Community Sanitation and Food Protection. Victim information is confidential and must be protected from unauthorized disclosure.

Children's camps must report epinephrine administration to the local health department whether or not they are participating in the auto injector program and regardless if medication was from the camp's stocked supply or brought to camp by a camper or staff.

Description of Incident:

Describe symptoms and circumstances surrounding the administration of the Epinephrine including the cause of anaphylaxis, signs and symptoms displayed by the patient prior to administration and the patient's response to the administered drug. Enter the events in the chronological order of their occurrence. Include available information about the event's outcome such as whether the patient was discharged from the hospital, returned to camp or went home. Use additional sheets if needed. When entering the narrative into eHIPS do not enter confidential information. Use the victims initials or similar code.

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Report completed by:______________________________________ **Title**:____________________________ **Date**: ______/______/______

Local Health Department:____ **Phone**: (______)_________________