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

Epinephrine Administration

Instructions: Report camper or staff epinephrine administrations, regardless if medication was from the camp's stocked supply or brought to camp by an individual or where it was administered (i.e., at the camp, hospital, etc.).
Shaded boxes are for local health department (LHD) use only.

FACILITY INFORMATION

Camp Name:_____ Facility Code:_____

eHIPS Incident #: _____
(LHD use only)

Camp Address: _____ 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 (Public Health Law Article 30, section 3000c)? ☐ Yes ☐ No

Was the camp emergency health care provider (EHCP) notified of the incident? ☐ Yes ☐ No ☐ N/A

eHIPS Victim ID #: _____
(LHD use only)

VICTIM INFORMATION

Name of Patient _____

Home Address _____

Town, Village, or City _____ State _____

Name of Parent or Guardian _____

Telephone Number _____

The box above contains confidential information that must be collected by the LHD for follow-up, and will be protected against unauthorized disclosure.

Age: _____ Weight:_____ Gender: ☐ Female ☐ Male ☐ Gender X ☐ Other

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? ☐ Thigh/Buttock ☐ Other (specify):_____

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 (specify): _____

Epinephrine training course: ☐ NYSDOH EMS (training program outline) ☐ Red Cross
☐ None ☐ Other (specify):_____

Name of EMS agency (ambulance) providing care:_____ Phone:_____

Name and location of health care facility patient was transported to:_____

Was patient admitted? ☐ Yes ☐ No

NARRATIVE: 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.

LHD use only. (Note: eHIPS will assign the incident and victim ID numbers when entered into the system.)

Information received by: _____ Title:_____

Report reviewed by: _____ Title: _____

Investigation/Follow-up Service:

Inspector's Name: _____ Date of Service: _____ Hours: _____
Service: ❑ On-site Investigation ❑ Telephone Follow-up

Inspector's Name: _____ Date of Service: _____ Hours: _____
Service: ❑ On-site Investigation ❑ Telephone Follow-up