

**Massachusetts Department of Public Health
Community Sanitation Program
Recreational Camp Injury Report Form**

In accordance with M.G.L. c. 111, §§ 3 and 127A and 105 CMR 430.000: Minimum Sanitation and Safety Standards for Recreational Camps for Children (State Sanitary Code Chapter IV), 105 CMR 430.154 specifically requires that a report be completed, on a form prescribed by the Massachusetts Department of Public Health, for each fatality or serious injury as a result of which a camper or staff person is sent home, or is brought to the hospital or a physician's office and where a positive diagnosis is made. Such injuries shall include, but shall not necessarily be limited to, those where suturing or resuscitation is required, bones are broken, or the child is admitted to the hospital. **A copy of each injury report must be sent to the Massachusetts Department of Public Health within SEVEN (7) days of the occurrence of the injury and the Brookline Health Department.**

PLEASE PROVIDE A COMPREHENSIVE AND THOROUGH RESPONSE TO EVERY QUESTION.

1. Name of Camp: _____
2. Street Address (please indicate the camp's in-session, physical address):

City/Town: _____ Zip Code: _____
3. Name of Camp Director: _____ 4. Telephone: _____
5. Name of Person Completing Form: _____
6. Today's Date: _____ 7. Date of injury: _____ 8. Time of Injury: _____ AM PM
9. Enter the number of campers and staff who were injured: ___ Camper ___ Staff member

Note: Fill out a separate form for each injured person

10. a) Age of person whose injury is described on this form: _____ b) Gender: M F
11. Where did the injury occur? On camp property Off camp property
12. Please specify the type of facility where the injury occurred:
 Athletic or recreational facility Pool
 Dorm or sleeping quarters Other water body (not pool)
 Motor vehicle Other, please specify: _____
13. What was the incident outcome? Please check all that apply:
 Injury Illness Death
14. Explain in detail how the injury occurred (e.g. what type of activity was the injured person engaged in when the injury occurred) and describe the nature of the injury. **Do not include names or other personal identifying information regarding the injured person or other involved parties.**

15. Type of injury. Please check all that apply:

- Alleged abuse or neglect
- Burn
- Fracture or dislocation
- Psychological or mental health issue
- Other, please specify: _____
- Allergic reaction
- Concussion
- Heat or cold (e.g., heat exhaustion, hypothermia)
- Undetermined
- Bite or sting
- Cut or laceration
- Muscle strain
- Viral or bacterial infection
- Bruise or contusion
- Drowning
- Near drowning

16. What body part(s) were injured? Please check all that apply:

- Head, neck, and/or face
- Torso, please specify:
 - Abdomen
 - Back
 - Chest
 - Hip
- Upper extremity, please specify:
 - Arm
 - Fingers
 - Hand
 - Shoulder
 - Wrist
- Lower extremity, please specify:
 - Ankle
 - Foot
 - Knee
 - Legs
 - Toes
- Internal
- Other, please specify: _____

17. Where was the person treated? Please check all that apply:

- Admitted to hospital
- Off-site medical facility (e.g., emergency room, physician’s or dentist’s office)
- On-site medical facility (e.g., clinic or infirmary)
- Other, please specify: _____

18. Was injured person sent home? Yes No

19. Did your camp change equipment, policies, or procedures as a result of this incident? Yes No

20. If yes, please check all that apply:

- Activity removed or forbidden
- Changes to equipment implemented
- New safety procedures implemented
- Safety education updated
- Venue changed or altered
- Other, please specify: _____

21. Briefly explain changes implemented as a result of this incident. If no changes were made, please explain why not.

PLEASE MAIL, FAX, OR EMAIL CAMP INJURY REPORTS TO:

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

BUREAU OF ENVIRONMENTAL HEALTH
COMMUNITY SANITATION PROGRAM
250 WASHINGTON STREET-7th FLOOR
BOSTON, MA 02108-4619

TELEPHONE (617)-624-5757 FAX (617) 624-5777

celestine.payne@state.ma.us

AND

BROOKLINE HEALTH DEPARTMENT – ENVIRONMENTAL HEALTH DIVISION

11 Pierce St Brookline MA 02445

Fax 617-799-1274

PMaloney@BrooklineMA.GOV