

# **An Analysis of Injuries in Maryland Summer Youth Camps, Year 2003 Cohort**



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**PHASE Internship**

**Maryland Department of Health and Mental Hygiene**

**Preceptor: Pamela Engle**

# Background



- First analysis in Maryland
- Literature search
  - New York Department of Health
  - Healthy Camps Study 2006-2011

# State of Maryland Specifics



- Reporting requirements
  - “Serious injury” –definition
  - Reporting mechanism
  - Time frame
  
- Youth camps types
  - Private (DHMH-regulated)
  - Government (self-regulated)



# Youth Camp Types



- Private (DHMH-regulated)
  - 95% reporting rate
  - 466 camps; 123,533 campers
- Government (self-regulated)
  - 65% reporting rate
  - 670 camps; 49,192 campers

# Objectives



- Database development
- Revise report form for 2006
- Develop instructions for form
- Support from Governor's Youth Camp Safety Advisory Council
- Make data collection useful
- Standardized reporting and analysis

# Statistics



- Injury rate
- Injuries by county
- Gender/age differences
- Injury location, activity and event
- Types of injuries
- Body part injured
- Changes made to camp

# Methods



- Database designed and developed
- Reports run/data analyzed from this database
- Medical report form revised (present to board in June)
- Instruction sheet devised (present to board in June)
- Population



# Limitations



- Injury only
- Year 2003 only
- Could not analyze some of the data
- Numerous people did data entry
- Poorly filled out and/or incomplete medical report forms

# Results and Discussion



- Total camps: 1,236
- Number of camps reporting  $\geq 1$  injury: 72
- Total campers: 172,725
- Total number of reported injuries: 218



# Results and discussion, cont.



- Overall injury rate:  
1.26 per 1,000 campers (0.126%)
- Camp reporting rate:  
6.3 injuries per 100 camps (6.3%)



County	# Injuries reported	# Camps Reporting $\geq 1$ injury/Total certified camps	% of camps in county reporting $\geq 1$ injury	% of injuries reported in county
Allegany	5	1/4	25	2
Anne Arundel	39	7/92	8	18
Baltimore City	17	5/80	6	8
Baltimore	11	9/117	8	5
Calvert	0	0/15	0	0
Caroline	4	1/10	10	2
Carroll	23	2/21	9.5	10
Cecil	8	2/10	20	4
Charles	2	2/16	12.5	<1
Dorchester	0	0/3	0	0
Frederick	6	3/34	9	3
Garrett	2	1/3	33	<1
Harford	8	2/18	11	4
Howard	7	3/72	4	3
Kent	20	2/9	22	9
Montgomery	48	18/209	8.6	22
Prince George's	5	4/326	1	2
Queen Anne's	3	1/8	12.5	1
St. Mary's	0	0/9	0	0
Somerset	0	0/0	0	0
Talbot	0	0/7	0	0
Washington	7	7/23	30	<1
Wicomico	1	1/23	4	.5
Worcester	1	1/4	25	.5
<b>Total</b>	<b>218/172,725=0.126%</b>	<b>72/1,136=6.3%</b>		<b><math>\approx 100\%</math></b>

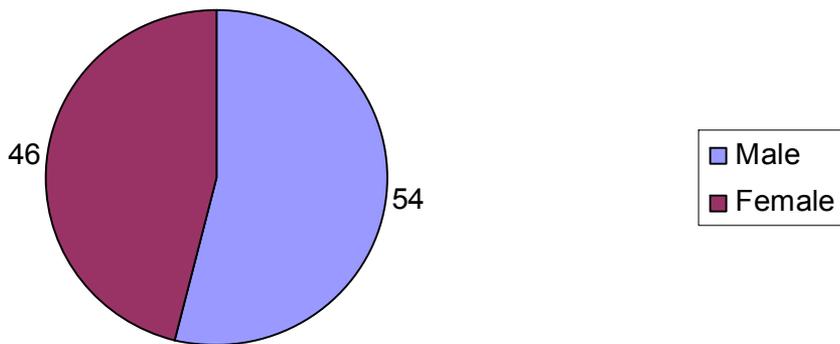
# Map of Maryland Counties

(and Baltimore City)



Map of Maryland by County,  
including Baltimore City

### Percentage of Injury by Gender



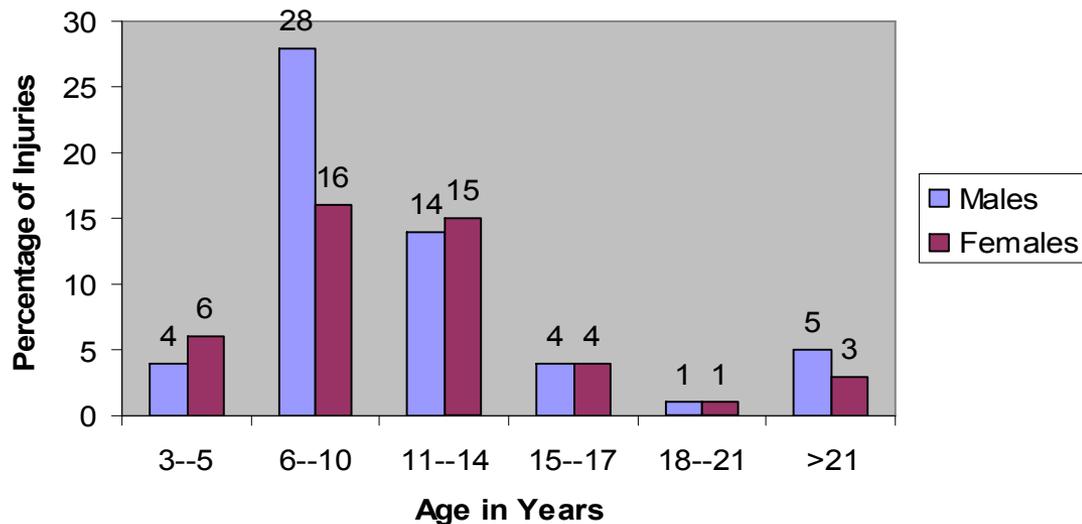
### Percentage of Injury by Gender



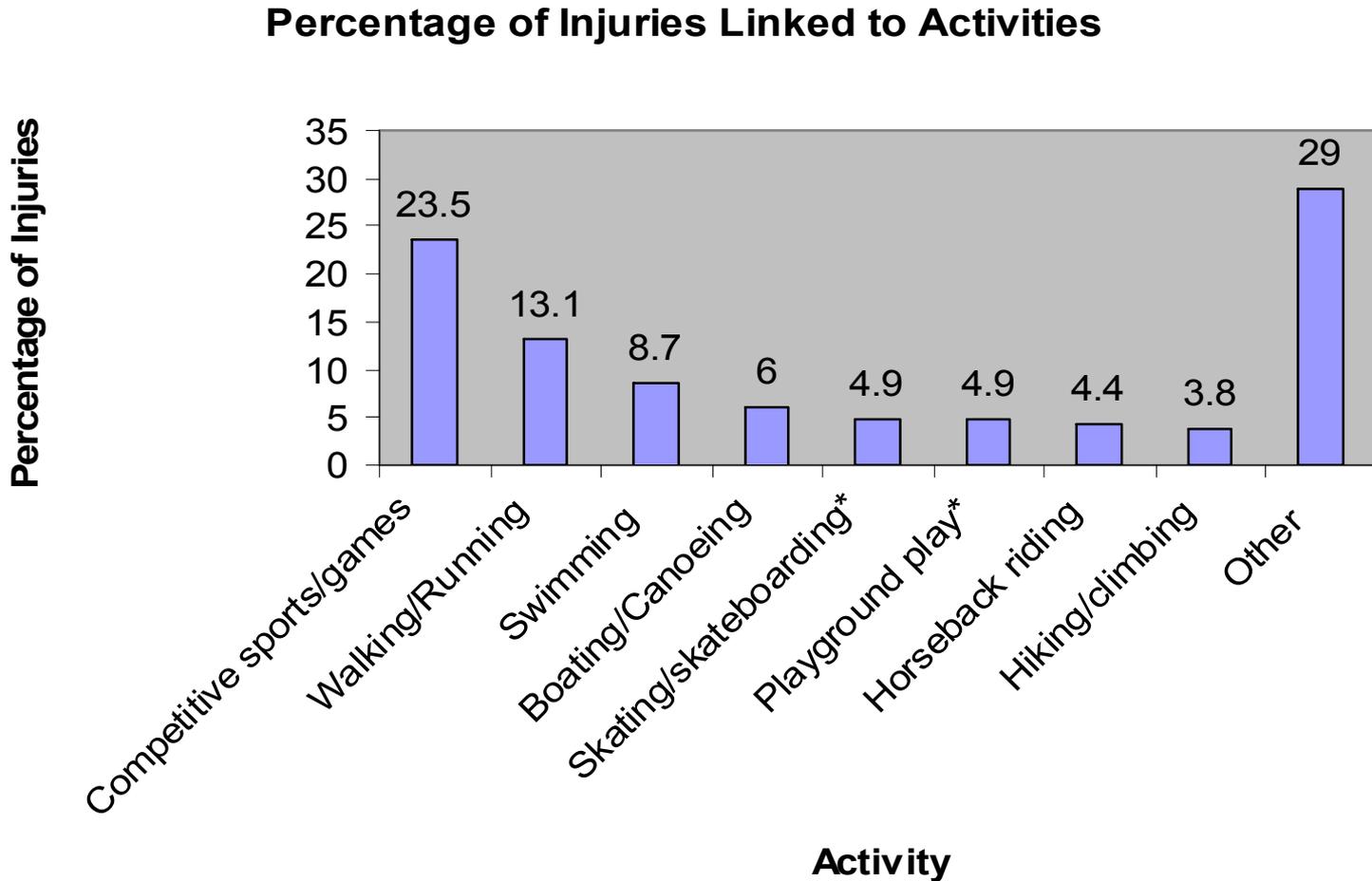
### Percentage of Injury by Age and Gender



### Percentage of Injury By Age and Gender

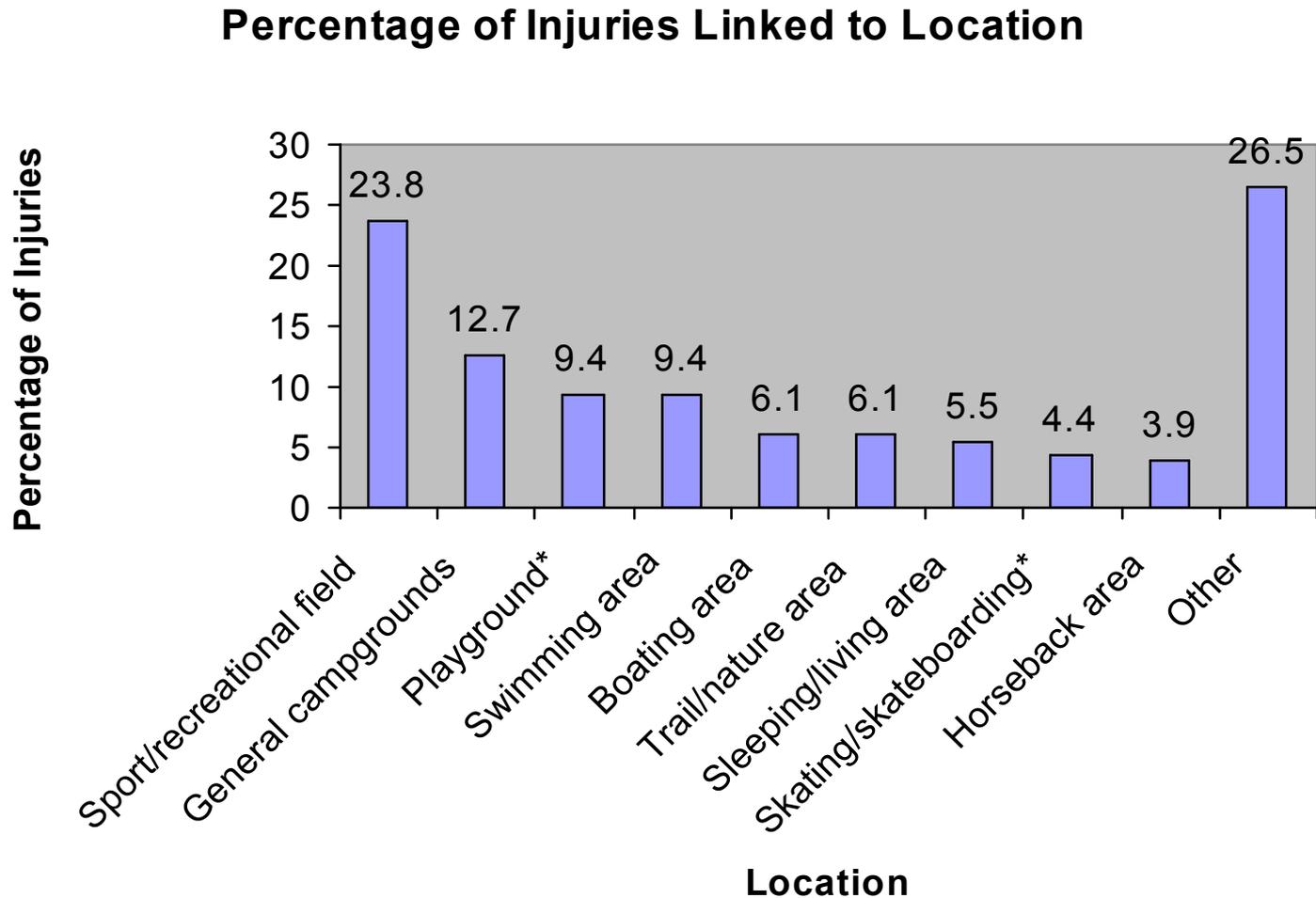


# Percentage of Injuries Linked to Activities



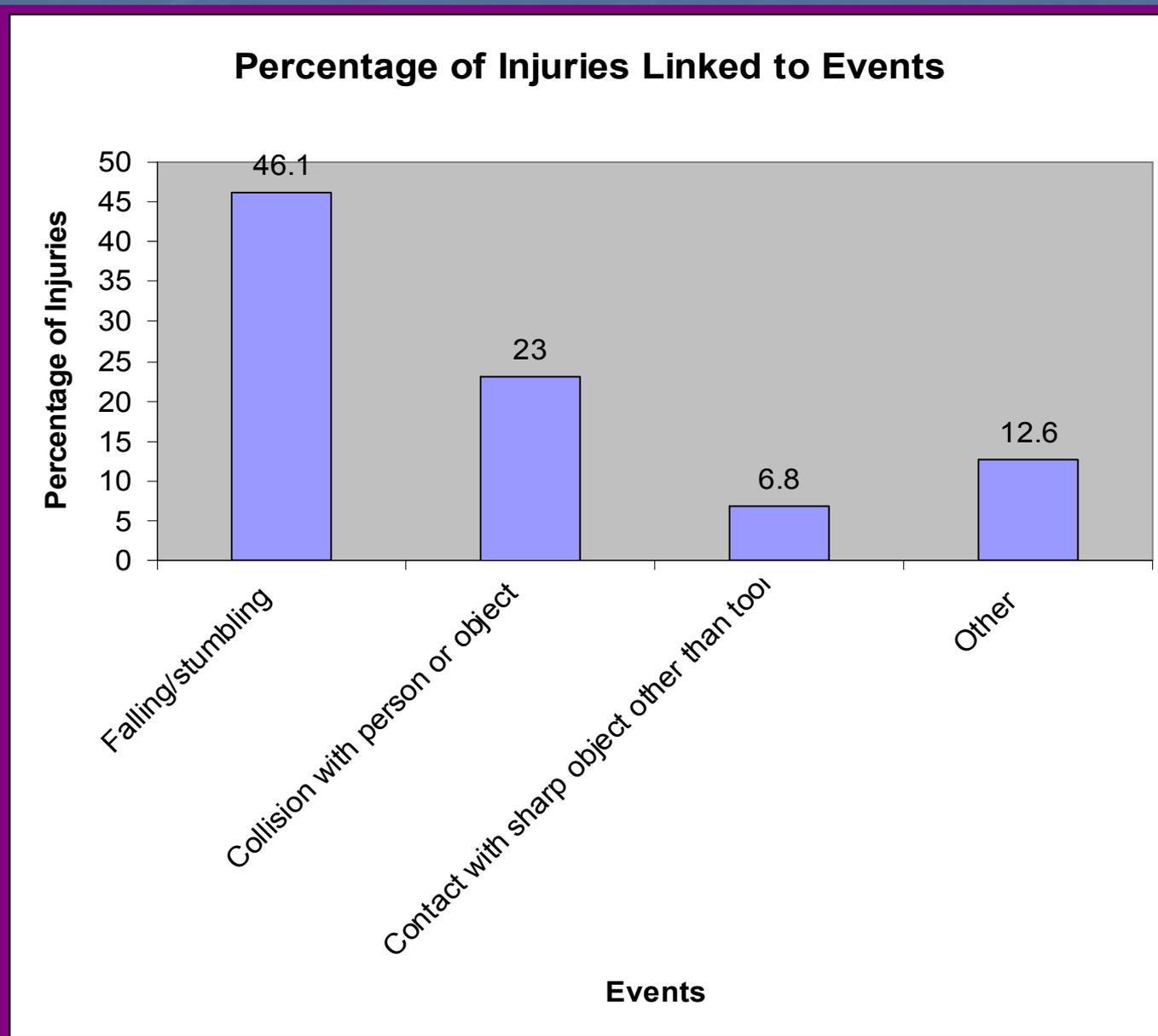
\*Activities listed under "other" but specified on report forms

# Percentage of Injuries Linked to Location



\*Activities listed under "other" but specified on report forms

# Percentage of Injuries Linked to Events



# Counts\* for Body Part Injured and Type of Injury



	Head/Neck	Trunk/Back	Arm/Hand	Leg/Foot
<b>Bruise</b>	12	2	13	8
<b>Burn</b>	0	0	1	0
<b>Fracture</b>	2	3	34	7
<b>Cut/Puncture</b>	34	2	10	13
<b>Sprain/dislocation</b>	0	0	13	11
<b>Scrape/Abrasion</b>	1	0	1	0
<b>Blunt Trauma</b>	0	0	0	0
<b>Other**</b>	23	2	7	6
<b>TOTAL</b>	72	9	79	45

\*Count versus percentage because some victims injured more than one body part in more than one way.

\*\*Other included 5 incidences of broken, loosened, or chipped teeth and 2 beestings

# Medical Report Form, Old/New



Camp Name	Camp Address	Camp Certification Number
		Name of County or Baltimore City
Date of Report (mm/dd/yyyy)	Date of Occurrence (mm/dd/yyyy)	Victim's Age
		Victim's Sex <input type="checkbox"/> M <input type="checkbox"/> F*Victim's Name:
Briefly describe the accident and subsequent injury or illness: *Name of Parent / Guardian: * <b>This information needs to be removed from the copy sent to DHMH.</b>		

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 YOUTH CAMP INJURY AND ILLNESS REPORT FORM  
 To be used for YEAR 2006 ONLY**

Division of Community Services  
 6 St. Paul Street, suite 1301, Baltimore MD 21202-1608  
 Phone 410-767-8417 Toll Free 1-877-4MD-DHMH, ext.8417  
 Fax 410-333-8926

<u>1.</u> Camp Name		<u>2.</u> Camp Address		<u>3.</u> Camp Certification Number	
				<u>4.</u> County or Baltimore City	
<u>5.</u> *Victim's Name		<u>6.</u> *Name of Parent /Guardian		<u>7.</u> *Remove all personal identifiers before forwarding a copy to DHMH	
<u>8.</u> Victim's Age	<u>9.</u> Victim's Sex <input type="checkbox"/> M  <input type="checkbox"/> F	<u>10.</u> List medication victim takes regularly (brand or generic name) <input type="checkbox"/> None		<u>11.</u> What is medication taken for?	
<u>12.</u> Date of Occurrence (mm/dd/yyyy)		<u>13.</u> Briefly describe the injury or illness. Remove personal identifiers before forwarding a copy to DHMH.			

# Section A-Injury (Old)



Complete Section A or Section B but not both

## Section A: INJURY

<p>Location of the incident causing the injury.</p> <p><input type="checkbox"/> Sleeping/Living quarters</p> <p><input type="checkbox"/> Kitchen/Dining area</p> <p><input type="checkbox"/> Shower/Toilet</p> <p><input type="checkbox"/> Other building</p> <p><input type="checkbox"/> Arts or Crafts area</p> <p><input type="checkbox"/> Trail or Nature area</p> <p><input type="checkbox"/> Archery area</p> <p><input type="checkbox"/> Riflery area</p> <p><input type="checkbox"/> Swimming area</p> <p><input type="checkbox"/> Boating area</p> <p><input type="checkbox"/> Horseback area</p> <p><input type="checkbox"/> Sport or Recreational Field or Court</p> <p><input type="checkbox"/> Campfire/Cookout area</p> <p><input type="checkbox"/> Road/Highway</p> <p><input type="checkbox"/> General Campgrounds</p> <p><input type="checkbox"/> Primitive/Outposts Camp</p> <p><input type="checkbox"/> Other (Specify):</p>	<p>What type of event caused the injury?</p> <p><input type="checkbox"/> Falling/Stumbling</p> <p><input type="checkbox"/> Collision with person or object</p> <p><input type="checkbox"/> Struck by another person</p> <p><input type="checkbox"/> Struck by missile</p> <p><input type="checkbox"/> Drowning or near drowning</p> <p><input type="checkbox"/> Bite or sting by insect or spider</p> <p><input type="checkbox"/> Bite or wound inflicted by animal</p> <p><input type="checkbox"/> Contact with excessive heat or flame</p> <p><input type="checkbox"/> Using a tool (including a cutting instrument)</p> <p><input type="checkbox"/> Contact with sharp object other than a tool</p> <p><input type="checkbox"/> Bite or wound inflicted by person</p> <p><input type="checkbox"/> Vehicle accident</p> <p><input type="checkbox"/> Other (Specify):</p>	<p>Activities at the time of the injury.</p> <p><input type="checkbox"/> Arts &amp; Crafts</p> <p><input type="checkbox"/> Archery/Riflery</p> <p><input type="checkbox"/> Horseback Riding</p> <p><input type="checkbox"/> Swimming</p> <p><input type="checkbox"/> Boating/Canoeing</p> <p><input type="checkbox"/> Hiking/Climbing</p> <p><input type="checkbox"/> Competitive Sports/ Games</p> <p><input type="checkbox"/> Fighting</p> <p><input type="checkbox"/> Horseplay</p> <p><input type="checkbox"/> Walking/Running</p> <p><input type="checkbox"/> Riding in vehicle</p> <p><input type="checkbox"/> Other (Specify):</p> <p>Name and title of staff member(s) supervising the activity:</p>																																
<p>Injury Data</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 15%;">Head/Neck</th> <th style="width: 15%;">Trunk</th> <th style="width: 10%;">Arm/Hand</th> </tr> </thead> <tbody> <tr> <td>Leg/Foot</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Bruise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Burn</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Fracture</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cut/puncture</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sprain/dislocation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other (Specify):</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			Head/Neck	Trunk	Arm/Hand	Leg/Foot				Bruise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cut/puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sprain/dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Was safety equipment available for the camper's use?</p> <p style="text-align: center;"><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> N/A</p> <p>If yes, was the camper using the equipment properly at the time of the accident?</p> <p style="text-align: center;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Did a staff member witness the injury?</p> <p style="text-align: center;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
	Head/Neck	Trunk	Arm/Hand																															
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# Section A-Injury (New)



<b>Section A: INJURY</b>																																																	
<p><u>14.</u> Camp location where injury occurred:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Amusement Park</li> <li><input type="checkbox"/> Archery Area</li> <li><input type="checkbox"/> Arts or Crafts Area</li> <li><input type="checkbox"/> Boating Area</li> <li><input type="checkbox"/> Campfire/Cookout Area</li> <li><input type="checkbox"/> General Campgrounds</li> <li><input type="checkbox"/> Horseback Area</li> <li><input type="checkbox"/> Kitchen/Dining Area</li> <li><input type="checkbox"/> Playground</li> <li><input type="checkbox"/> Primitive/Outposts Camp</li> <li><input type="checkbox"/> Riflery Area</li> <li><input type="checkbox"/> Road/Highway</li> <li><input type="checkbox"/> Shower/Toilet</li> <li><input type="checkbox"/> Sleeping/Living quarters</li> <li><input type="checkbox"/> Sport or Recreational Field or Court</li> <li><input type="checkbox"/> Swimming Area</li> <li><input type="checkbox"/> Trail or Nature Area</li> <li><input type="checkbox"/> Other (Specify):</li> </ul>	<p><u>15.</u> Type of event that caused injury:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bite or Wound Inflicted by Animal</li> <li><input type="checkbox"/> Bite or Wound Inflicted by Human</li> <li><input type="checkbox"/> Bite or Sting by Insect or Spider</li> <li><input type="checkbox"/> Collision with Person or Object</li> <li><input type="checkbox"/> Contact with Excessive Heat or Flame</li> <li><input type="checkbox"/> Contact with Sharp Object Other than a Tool</li> <li><input type="checkbox"/> Contact with Tool (Including a Cutting Instrument)</li> <li><input type="checkbox"/> Drowning or Near-Drowning</li> <li><input type="checkbox"/> Falling/Stumbling</li> <li><input type="checkbox"/> Struck by Missile</li> <li><input type="checkbox"/> Struck by Person</li> <li><input type="checkbox"/> Vehicle Accident</li> <li><input type="checkbox"/> Other (Specify):</li> </ul>	<p><u>16.</u> Activities at the time of the injury:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arts &amp; Crafts</li> <li><input type="checkbox"/> Archery/Riflery</li> <li><input type="checkbox"/> Boating/Canoeing</li> <li><input type="checkbox"/> Competitive Sports/Games (Specify):</li> <li><input type="checkbox"/> Fighting</li> <li><input type="checkbox"/> Hiking/Climbing</li> <li><input type="checkbox"/> Horseback Riding</li> <li><input type="checkbox"/> Horseplay</li> <li><input type="checkbox"/> Riding in vehicle</li> <li><input type="checkbox"/> Swimming</li> <li><input type="checkbox"/> Walking/Running</li> <li><input type="checkbox"/> Other (Specify):</li> </ul>																																															
			<p><u>17.</u> Was activity supervised?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Unknown</p>																																														
			<p><u>18.</u> If yes :</p> <p>Number of Campers Present: _____</p> <p>Number of Staff Present: _____</p>																																														
<p><u>19.</u> Body Part Injured/Type of Injury:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 15%;">Head/Neck</th> <th style="width: 15%;">Trunk/Back</th> <th style="width: 15%;">Arm/Hand</th> <th style="width: 15%;">Leg/Foot</th> </tr> </thead> <tbody> <tr> <td>Blunt Trauma</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Bruise</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Burn</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cut/puncture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Fracture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Scrape/Abrasion</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sprain/dislocation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other (Specify):</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>			Head/Neck	Trunk/Back	Arm/Hand	Leg/Foot	Blunt Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cut/puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scrape/Abrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sprain/dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><u>20.</u> Was safety equipment available for the victim's use?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Not applicable</p>		
	Head/Neck	Trunk/Back	Arm/Hand	Leg/Foot																																													
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		<p><u>21.</u> If yes, was the victim using the equipment properly at the time of injury?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																																															
		<p><u>22.</u> Did a staff member witness the injury?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>																																															

## Section B: ILLNESS

Infectious or inflammatory disease

- Respiratory infection
- Gastroenteritis (diarrhea, vomiting)
- Dental (toothache, gum abscess, etc.)
- Ear ache or ear infection
- Appendicitis
- Seizure
- Other (Specify):

Allergic diseases (asthma, pollen, foods, etc.)

Specify:

Toxic disease (insect bites, poisoning, drug use, etc.)

Specify:

Other conditions not listed in A, B, or C – Include the pertinent signs and symptoms.

- Psychological disorders – Especially homesickness
- Undiagnosed conditions – Fever of unknown cause, fainting, etc.
- Other – Nosebleeds, indigestion, etc.

Signs and symptoms:

Camper sent home: Date \_\_\_\_\_ Time \_\_\_\_\_

Old



## Section B: ILLNESS

23. Infectious or inflammatory disease

- Dental Problem (toothache, gum abscess, etc.)
- Ear Ache or Ear Infection
- Gastroenteritis (diarrhea, vomiting)
- Respiratory Infection
- Sore Throat
- Other (Specify):

24. Allergic Reaction/Condition: (Allergic Rhinitis, Atopic Dermatitis, Eczema, Etc.)

Specify:

25. Toxic disease (Venoms-Insect/Snake Bites, Poisoning, Plants- Poison Ivy, Oak, or Sumac, Drug or Alcohol Overdose, Etc.)

Specify:

26. Asthma:

- Known Exposure:  
(Specify-Food, Mold, Dust, Animal, Pollen, Latex, Etc.):
- Unknown Exposure

27. Other conditions not listed in 23-26.

- Heat Stroke/Heat Exhaustion
- Homesickness
- Psychological Disorders
- Seizure
- Other (Specify):

New



Section C: GENERAL INFORMATION		
What medical service was provided? <input type="checkbox"/> Examination with no further treatment <input type="checkbox"/> Antiseptic/Antibiotic <input type="checkbox"/> Anti-inflammatory/Analgesic <input type="checkbox"/> Supportive (bed rest, physiotherapy) <input type="checkbox"/> Gastrointestinal (antacid, laxative) <input type="checkbox"/> Antihistamine/Decongestant <input type="checkbox"/> Psychotropic (tranquilizers, etc.) <input type="checkbox"/> X-ray or diagnostic test on (date) _____ <input type="checkbox"/> Stitches <input type="checkbox"/> Cast or sling <input type="checkbox"/> Dressing <input type="checkbox"/> Other (Specify):	Where was medical service provided? <input type="checkbox"/> Treated in Camp Infirmary or First Aid Station <input type="checkbox"/> Treated in Hospital Emergency Room, Clinic Physician's Office <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Other (Specify):	Disposition: <input type="checkbox"/> No disability <input type="checkbox"/> Temporary disability <input type="checkbox"/> Permanent disability <input type="checkbox"/> Unknown <input type="checkbox"/> Fatal
	Who provided medical service? <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> EMS Responder <input type="checkbox"/> Other (Specify):	Did camper miss any full days of camp? <input type="checkbox"/> Yes # ____ <input type="checkbox"/> No  Did camper have positive lab tests or x-rays? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
What changes were made in the camp, its environment, or its operation as a result of this illness or injury? <input type="checkbox"/> Restricted camper <input type="checkbox"/> Individual isolated <input type="checkbox"/> Use of disinfectants increased <input type="checkbox"/> Poison ivy/oak destroyed <input type="checkbox"/> Repairs or improvements <input type="checkbox"/> Safety equipment <input type="checkbox"/> Other (Specify): Describe:		
<input type="checkbox"/> Rest periods increased <input type="checkbox"/> Insects sprayed <input type="checkbox"/> Camp Area(s) restricted <input type="checkbox"/> Rules changed or added <input type="checkbox"/> Protective devices <input type="checkbox"/> No changes		
<input type="checkbox"/> Beds rearranged <input type="checkbox"/> Supervision improved		

Old



Section C: GENERAL INFORMATION		
28. What medical service was provided? <input type="checkbox"/> Antibiotic <input type="checkbox"/> Antihistamine/Decongestant <input type="checkbox"/> Anti-inflammatory/Analgesic <input type="checkbox"/> Antiseptic <input type="checkbox"/> Cast, sling, or splint <input type="checkbox"/> Dressing <input type="checkbox"/> Examination with No Further Treatment <input type="checkbox"/> Gastrointestinal (Antacid, Laxative) <input type="checkbox"/> Ice <input type="checkbox"/> Stitches <input type="checkbox"/> Supportive (Bed Rest, Physiotherapy) <input type="checkbox"/> Other (Specify):	29. Where was medical service provided? <input type="checkbox"/> Treated in Camp Infirmary or First Aid Station <input type="checkbox"/> Treated in Hospital Emergency Room, Clinic Physician's Office <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Other (Specify):	30. Who provided medical service and diagnosis? <input type="checkbox"/> Dentist <input type="checkbox"/> EMS Responder <input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Other (Specify):
	31. Final Outcome: <input type="checkbox"/> No permanent disability <input type="checkbox"/> Permanent disability <input type="checkbox"/> Unknown <input type="checkbox"/> Fatal (Specify investigating authority and report number):	32. Did victim miss any days of camp due to injury or illness? <input type="checkbox"/> No <input type="checkbox"/> Yes, <u>Specify Number of Days Missed</u> :
		33. Did victim have x-rays? <input type="checkbox"/> No <input type="checkbox"/> Yes, <u>Result</u> :
		34. Did victim have lab tests? <input type="checkbox"/> No <input type="checkbox"/> Yes, <u>Result</u> :
35. Were changes made to the camp, its environment, or its operation as a result of the injury or illness? <input type="checkbox"/> No  <input type="checkbox"/> Yes (Specify):		

New



**Section D: REPORT COMPLETED BY**

36. Print Name and Title

37. Date of Report (mm/dd/yyyy)

38. Signature

39. Phone number(s)

During camp:

Year-round:

Other:

# Instruction sheet



## INSTRUCTIONS FOR FILLING OUT THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH) 2006 YOUTH CAMP MEDICAL REPORT FORM

### **Please use only the 2006 Report Form**

*Fill out Numbers 1-13 and Numbers 28-39 (Section C and D) for all reports. If victim is injured: Fill out Numbers 14-22 (Section A) in addition to the above. If victim is ill: Fill out Numbers 23-27 (Section B) in addition to the above. Do not fill out both sections A and B .*

***Complete this form only for a serious injury or illness. That is, if the victim requires medical care from a doctor, nurse, dentist, or emergency medical personnel and is treated at a doctor's office, emergency department, or hospital; or if the victim requires laboratory work, x-rays, or other medical scans. Do not complete this form for simple first aid provided at camp such as care for scrapes, bruises, or a nosebleed.***

***DHMH should receive this form, filled out in its entirety, within 2 weeks of the end of camp along with the camp's annual report. However, in the case of a severe injury or illness (admission to a hospital, not just treatment in the emergency room), resuscitation (CPR), or death, DHMH should be notified verbally within 24 hours and the form sent to DHMH within one week of the incident.***

In all cases of serious injury or illness, the victim's parent or guardian should be notified immediately of the illness or injury.

DHMH Address: DHMH  
Division of Community Services  
6 St. Paul Street, Suite 1301  
Baltimore MD 21202-1608

DHMH Phone Number: (410) 767-8417  
Toll Free 1-877-4MD-DHMH, ext. 8417

DHMH Fax Number: (410) 333-8926

**Numbers 1-13, fill out for all victims of injury and illness**

1. Camp Name: Write out camp name in full
2. Camp Address: Write out in full
3. Camp Certification Number: Write out in full; obtain from DHMH camp certificate or letter of compliance
4. County or Baltimore City: Write out in full
5. Victim's Name: For your records only. Remove victim's name prior to sending a copy of the report to DHMH. (White or black out the name on the copy sent to DHMH.)
6. Name of Parent/Guardian: For your records only. Remove names prior to sending a copy of this report to the DHMH. (White or black out the name on the copy sent to DHMH.)
7. \*Make sure Name of Victim, Name of Parent/Guardian or other personal identifiers (Address of Victim/Parents, Birthdate, Social Security Number, or Patient ID Number) are removed on the copy of the report forwarded to DHMH. White or black out the shaded areas or other victim identifiers on the *copy* of the report sent to DHMH.
8. Victim's Age: Write age in years, no birth dates
9. Victim's Sex: Check (m) for male or (f) for female
10. List medication the victim takes regularly: If the victim takes a medication regularly for an illness or injury, please write name of the medication here. If victim takes no known medications, check the box that reads "none"
11. What is medication taken for?: If known, please fill in here why the medication is being taken by the victim (e.g. ritalin for ADHD, budesonide for asthma, etc.)
12. Date of the occurrence (month/day/year): Date of injury or illness
13. Brief description of the illness or injury: Be as specific as possible and to the point

**Section A (Numbers 14-22), fill out for victims of injury only (do not fill out for illness)**

14. Location of the incident causing the injury: Check one or write in specific location under “other” if the location is not listed
15. Type of event causing injury: Check one or write in specific event under “other” if the event is not listed
16. Activities at the time of the injury: Check one or write in specific activity under “other” if the activity is not listed. (Note: If a victim is injured during a competitive sport/game, please specify the sport here)
17. Was activity supervised? Check yes or no.
18. If yes, write in number of staff present and number of campers present
19. Body part injured/type of injury: Check the type of injury (bruise, burn, etc.) and the body part(s) injured (like head/neck, trunk, etc.)
20. Was safety equipment available for the victim’s use? Check yes or no
21. If yes, was the camper using the equipment properly at the time of the accident? Check yes or no
22. Did a staff member witness the injury? Check yes or no

**Section B (Numbers 23-28), fill out for victims of illness only (do not fill out for injury)**

23. Infectious or inflammatory disease: Check a box only if illness is listed
24. Allergic Disease: Write allergy trigger, if known or specify condition
25. Toxic Disease: Write toxin trigger, if known or specify condition
26. Asthma: Write asthma trigger, if known or specify unknown
27. Other conditions: Check a box if illness is listed or write in illness under “other”

**Section C (Numbers 29-40), fill out for all victims of injury and illness**

28. What medical service was provided? Check box/boxes or write in under “other”
29. Where was medical service provided? Check box or write in under “other”
30. Who provided medical service and made diagnosis? Check box or write in under “other”
31. Final Outcome: Check one box. *\*In case of fatality (death of the victim), please provide the name of the investigating authority and the report number\**
32. Did victim miss any days of camp due to illness or injury? Check yes or no and, if applicable, fill in number of days of camp that victim missed
33. Did victim have x-rays? Check yes or no. If yes, write in the result of the x-ray
34. Did victim have laboratory tests? Check yes or no. If yes, write in the result of the laboratory test.
35. What changes were made in the camp, its environment, or its operation as a result of this incident? Check “no” if no changes were made. Otherwise, check “Yes” and specify the change or changes made.

**Section D (Numbers 36-39), fill out for all victims of injury and illness**

36. Print name and title: Write in full name and full camp title
37. Date of report: month/day/year
38. Signature: The person who filled out the report should sign the report
39. Phone numbers: Fill out phone numbers that you can be reached at both during camp and the rest of the year

*For questions, contact DHMH, Division of Community at the above numbers.*

# Conclusions



- Future analysis of trends (playground injuries)
- Standardized reporting, data entry, and data analysis will allow for valid comparisons
- Report forms needed major revision; will now provide more useful information (sports, med.s)
- Instruction sheet should help with accuracy of reporting and should increase reporting of serious injuries/illnesses
- Training/enforcement needed; balanced with DHMH human resource capacity
- Valuable information in DHMH camp files

# Questions that need answers



- Do certain diagnoses lead to greater injury rates? (ADHD, etc.)
- Is supervision adequate at camps?
- Should there be additional supervision for one gender over the other? Should there be additional supervision/safety training for certain activities?
- What are injury outcomes at camps?
- Are certain sports associated with more injuries and, if so, what can be done to prevent sports injuries?

# Recognition



- Pamela Engle
- Alan Price
- Dr. Michel Ibrahim
- Dipti Shah
- Linda, Shirl, Karol Ann, Rich, & Pam's husband Larry

# References



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