

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

This form is issued pursuant to 105 CMR 430.000: Minimum Standards for Recreational Camps for Children (State Sanitary Code Chapter IV) which requires a camp to submit a report of each fatality or serious injury as a result of which a camper, staff person, or volunteer is sent home, or is brought to the hospital or a physician's office and a positive diagnosis is made. (105 CMR 430.154) Injuries include, but are not limited to, suturing or resuscitation needs, broken bones, or hospital admittance.

**A copy of this report must be sent to the Massachusetts Department of Public Health and the local Board of Health within SEVEN (7) days of the occurrence of the injury.**

**This form may also be used for notification of filing a 51A Report with the Department of Children and Families (DCF) (105 CMR 430.093). If using for that purpose, please ONLY fill out questions # 1 - 6, and 22.**

**PLEASE PROVIDE A COMPREHENSIVE AND THOROUGH RESPONSE TO EACH 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: \_\_\_\_\_

**If a fatality or serious injury occurred at camp, complete the following. To notify of a 51A filing ONLY, skip to Question 22:**

7. Date of Incident: \_\_\_\_\_ 8. Time of Incident: \_\_\_\_\_  AM  PM

9. Number of individuals who were injured or ill: \_\_\_ Camper \_\_\_ Staff Person \_\_\_ Volunteer

**Note: Fill out a separate form for each injured individual**

10. a) Age of individual whose incident is described on this form: \_\_\_\_\_ b) Gender:  M  F

11. Where did the incident occur?  On camp property  Off camp property

12. Please specify the type of facility where the incident occurred:

- |  |   |
|--|---|
| <input type="checkbox"/> Athletic or recreational facility | <input type="checkbox"/> Pool                         |
| <input type="checkbox"/> Dorm or sleeping quarters         | <input type="checkbox"/> Other water body (not pool)  |
| <input type="checkbox"/> Motor vehicle                     | <input type="checkbox"/> Other, please specify: _____ |

13. What was the incident outcome? Please check all that apply:

- Injury  Illness  Death

14. Explain in detail how the incident occurred (e.g. the type of activity was the individual was engaged in, the initial symptoms exhibited) and describe the nature of the injury or illness. **Do not include names or other personal identifying information regarding the injured individual or other involved parties.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Report ID # (internal use only): \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Cross-reference # (internal use only): \_\_\_\_ - \_\_\_\_ - \_\_\_\_

(continued over)  
Revised March 2019

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

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Allergic reaction                                 | <input type="checkbox"/> Bite or sting                | <input type="checkbox"/> Bruise or contusion                   | <input type="checkbox"/> Burn                                 |
| <input type="checkbox"/> Concussion  | <input type="checkbox"/> Cut or laceration            | <input type="checkbox"/> Drowning                              | <input type="checkbox"/> Fracture or dislocation              |
| <input type="checkbox"/> Heat or cold (e.g., heat exhaustion, hypothermia) | <input type="checkbox"/> Muscle strain                | <input type="checkbox"/> Near drowning                         | <input type="checkbox"/> Psychological or mental health issue |
| <input type="checkbox"/> Undetermined                                      | <input type="checkbox"/> Viral or bacterial infection | <input type="checkbox"/> Other, please specify in space below: |   |

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

- Head, neck, and/or face
- Torso, please specify:
- |                                  |                               |                                |                              |
|----------------------------------|-------------------------------|--------------------------------|------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back | <input type="checkbox"/> Chest | <input type="checkbox"/> Hip |
|----------------------------------|-------------------------------|--------------------------------|------------------------------|
- Upper extremity, please specify:
- |                              |                                  |                               |                                   |                                |
|------------------------------|----------------------------------|-------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Arm | <input type="checkbox"/> Fingers | <input type="checkbox"/> Hand | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist |
|------------------------------|----------------------------------|-------------------------------|-----------------------------------|--------------------------------|
- Lower extremity, please specify:
- |                                |                               |                               |                               |                               |
|--------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Knee | <input type="checkbox"/> Legs | <input type="checkbox"/> Toes |
|--------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
- Internal
- Other, please specify: \_\_\_\_\_

17. Where was the individual 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 the individual 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 prohibited
- 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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

22. Did a suspected incident of child abuse or neglect occur at camp, resulting in the filing of 51A report to DCF?  YES  NO  
If yes, date report sent to DCF: \_\_\_\_\_

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

1) 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](mailto:celestine.payne@state.ma.us)

2) Wellesley Health Department  
Telephone: 781.235.0135 / Fax 781.235.4685