

Organizational Camp Accident / Fatality Report

State of Oregon
Oregon Health Authority
Public Health Division

This report must be completed for every serious accident, those requiring off-site treatment, or any fatality involving an organizational camp program. It is the **responsibility of the camp operator** to submit the completed form promptly to the **Oregon Health Authority, Organizational Camp Program, 800 NE Oregon, Suite 608, Portland, OR 97232-2162**

Food, Pools and Lodging—Health & Safety
800 NE Oregon Street, Suite 608
Portland, Oregon 97232-2162
Phone (971) 673-0451
FAX (971) 673-0457

Communicable diseases are to be reported to the county health department communicable disease program.



Date of Incident	Time: _____ am _____ pm
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Accident ID # YY - MM - DD - Accession #
Official Use Only

Victim Information – Please do not identify the victim by name. You are encouraged to assign an identifier to the accident in case we have to contact you.

Unique Identifier	Victim's Residence City or Town	State	Zip Code
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<input type="checkbox"/> Fatal <input type="checkbox"/> Non-Fatal	Age of Victim:(yrs)	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	Camper <input type="checkbox"/> Staff <input type="checkbox"/>
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Area of the Body Injured:	Type of Injury: (Check all that Apply)
	<input type="checkbox"/> Abrasion or Contusion <input type="checkbox"/> Strain or Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Allergy / Asthma Reaction <input type="checkbox"/> Diabetic Emergency <input type="checkbox"/> Other (Specify)

Treatment Required: (Check all that Apply)			
<input type="checkbox"/> No Treatment	<input type="checkbox"/> First Aid	<input type="checkbox"/> CPR (<input type="checkbox"/> Manual <input type="checkbox"/> AED <input type="checkbox"/> Oxygen)	
<input type="checkbox"/> Doctor's Office/Emergency Room	<input type="checkbox"/> Admitted to Hospital		
<input type="checkbox"/> Other (Specify)			

Camp Information	Camp License #
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Name of Camp		
Address Number	Street	
City	State	Zip Code
Contact Person	Position	Phone

Was the activity causing the injury supervised ? <input type="checkbox"/> Yes <input type="checkbox"/> No	The supervision was provided by Camp Staff trained for this activity <input type="checkbox"/> Untrained Staff or Volunteer <input type="checkbox"/>
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Location of accident: <ul style="list-style-type: none"><input type="checkbox"/> Campsite / Cabin<input type="checkbox"/> Dining Hall / Food Service<input type="checkbox"/> Waterfront *<input type="checkbox"/> Canoeing / Boating<input type="checkbox"/> Target Sports<input type="checkbox"/> Horseback Riding<input type="checkbox"/> Ropes Course<input type="checkbox"/> Arts & Crafts<input type="checkbox"/> Hiking Trail<input type="checkbox"/> Off-site activity: _____<input type="checkbox"/> Other: _____ <p>* For swimming pool /spa incidents please use the Public Swimming Pool Accident Report form.</p>	Cause of injury or fatality: (Check all that apply) <ul style="list-style-type: none"><input type="checkbox"/> Horseplay<input type="checkbox"/> Improper Use of Equipment<input type="checkbox"/> Poor / No Supervision<input type="checkbox"/> Equipment Failure<input type="checkbox"/> Activity Area Design<input type="checkbox"/> Lack of Safety Equipment<input type="checkbox"/> Non-use or Improper Use of Safety Equipment<input type="checkbox"/> Drug / Alcohol Use or Abuse<input type="checkbox"/> Use of chemicals, paint, cleaning supplies<input type="checkbox"/> Weather<input type="checkbox"/> Other (describe)
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Were Others Injured: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Name(s)

Describe what happened: (Please be legible) Use "victim," "camper," "injured party," etc. No victim or parent names. Naming of rescuers, witnesses or others may be appropriate. Do not attach EMS, police or insurance reports in lieu of filling this section out. Other reports adding information are appropriate, but may be disposed of after review to protect the injured party's personal information.
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Print or Type Name & Position:	Signature:	Date:
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