|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DFRS-BFRB-055.docx (rev. 10/23) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Wisconsin Department of Agriculture, Trade and Consumer Protection  Division of Food and Recreational Safety  P.O. Box 8911, Madison, WI 53708-8911 | | | | | | | | | | | | | | | | | | *Wis. Admin. Code § ATCP 78.29* | | | | | | |
| Recreational and Educational Camp Death, Injury, & Illness Report | | | | | | | | | | | | | | | | | | | | | | | | | |
| The camp shall report incidents resulting in serious injury, illness, or death, where an emergency medical service response is required, by the end of the next working day following the incident, by phone or email to the department or its agent. Completion of this form is recommended to meet reporting requirements. Failure to report incidents is subject to compliance action under Wis. Stat. ch. 97 and Wis. Admin. Code ch. ATCP 78. Personally identifiable information you provide may be used for purposes other than that for which it was collected. Wis. Stat. § 15.04 (1)(m). | | | | | | | | | | | | | | | | | | | | | | | | | |
| Important Note: Report only those injuries or illnesses that require assistance from emergency medical service response is required.  Please print all information.  Email the completed form to datcpdfrsrec@wisconsin.gov or, if licensed by an Agent Health Department, contact your them to determine how to submit form and meet the submission deadline. | | | | | | | | | | | | | | | | | | | | | | | | | |
| ESTABLISHMENT/DBA INFORMATION: | | | | | | | | | | | | | | | | | | | | | | | | | |
| ESTABLISHMENT NAME | | | | | | | | | | | | | | | LICENSE/ID # | | | | | | | | | | |
| ESTABLISHMENT STREET ADDRESS | | | | | | | | | CITY: | | | | | | | | | | | | STATE | | ZIP | | |
| LEGAL LICENSEE NAME | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTACT PERSON | | | | | | | | | | PHONE NUMBER  (     )     - | | | | | | | | | | | | | | | |
| INJURED PARTY INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| LAST NAME OF INJURED PARTY | | | | FIRST NAME | | | | | | | | MIDDLE | D.O.B. (mm/dd/yyyy) | | | | | CAMPER | | | | STAFF | | | VISITOR |
| ADDRESS | | | | | | | CITY | | | | | | | STATE | | ZIP | | | | | PHONE NUMBER  (     )     - | | | | |
| NAME OF PARENT/GUARDIAN (IF MINOR) | | | | | | | | | | | | | | | | | PHONE NUMBER  (     )     - | | | | | | | | |
| ADDRESS | | | | | | | CITY | | | | | | | | | | | | | | STATE | | ZIP | | |
| INCEDENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| TYPE OF INJURY: | | | INJURY | | DEATH | | | ILLNESS | | | | | | | | | | | | | | | | | |
| DATE OF  INCIDENCE | | DAY OF WEEK | | | | MONTH | | | | | DAY | | YEAR | | | | | | | TIME | | | | AM  PM | |
| Detailed description of incident (Describe the sequence of activity in detail, including what the injured person was doing at the time of the incident and location on the premises or primitive camping area where incident occurred): | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If incident occurred during aquatic program activity, list name(s) of lifeguard on duty: | | | | | | | | | |
| NAME | | | | | NAME | | | | |
| NAME | | | | | NAME | | | | |
| Check applicable immediate treatment provided prior to ambulance arrival:  First Aid  CPR  AED | | | | | | | | | |
| By whom? |  | | | | | | | | |
|  | | |  | | |  | | (     )     - | |
| SUBMITTED BY | | | POSITION | | | DATE | | PHONE NUMBER |
|  | | | | | | | | |
| OFFICE USE ONLY: | | | | | | | | |
| **AGENT HEALTH DEPARTMENT OR DATCP FIELD SANITARIAN USE ONLY** | | | | | | | | |
| NAME | | | | | | | TITLE | |
| AGENCY | | | | | | | DATE | |
| EMAIL ADDRESS | | | | | | | PHONE NUMBER  (     )     - | |
| COMMENTS | | | | | | | | |
| OFFICIAL’S SIGNATURE | | | | PRINTED NAME | | | | |
| Agent or DATCP Sanitarian –  please submit documents by email to: DATCPDFRSRetail@wi.gov (for a food facility) [DATCPDFRSRec@wi.gov](mailto:DATCPDFRSRec@wi.gov) (for a recreational facility) | | | | Or mail to:  DATCP – DFRS Attn: Technical Section PO Box 8911 Madison, WI 53708-8911 | | | | |
| License Category: | |  | | | | | | |