NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Children's Camp Facility and Staff Description

Instructions

Complete the items that are applicable to the camp's operation; use additional sheets if necessary. Submit the completed form and other required application materials to the local health department (LHD) at least 60 days prior to camp operation. Information that is not available should be identified as "Pending." For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available.

Facility

Facility Name: _____

Facility Code: _____ Date Open: ___/___/___ Date Close: ___/___/___ Are 20% or more of the campers developmentally disabled? ☐ Yes ☐ No

Activities available to campers

For activities identified with a "*", please further specify the activity in the space provided.

☐ Amusement Parks	☐ Classroom Instruction	☐ Ice Skating	☐ Roller Skating/Blading	☐ Other Water Activities*
☐ Aquatic Theme Parks	☐ Cooking	☐ Martial Arts	☐ Ropes/Challenge Course	☐ Other*
☐ Archery	☐ Dancing/Acting	☐ Mountain Boarding	☐ Skate Boarding	* _____
☐ Arts and Crafts	☐ Gymnastics	☐ Nature Study	☐ Sports	_____
☐ Bicycling	☐ High Adventure*	☐ Organized Games (Play)	☐ Swimming – On-Site	_____
☐ Boating/Canoeing/Rafting	☐ Hiking	☐ Petting Zoo	☐ Swimming – Off-Site	_____
☐ Camp Trips	☐ Horseback Riding	☐ Riflery	☐ Swimming – Wilderness	_____

Camper Capacity

For each session, select the camp type, specify the number of days in the session and provide camper capacity information. Use separate session rows if both a day camp and overnight camp operate at the same time. **Use actual attendance data from last season.** If the camp did not operate last season, use estimates and check this box ☐. Attach additional sheets if needed.

	Camp Type			Age Group											
				1 to 5		6 & 7		8 to 12		13 to 15		16 & 17		CITs **	
	Day	Overnight	Number of Days	male	female	male	female	male	female	male	female	male	female	male	female
Session 1	☐	☐													
Session 2	☐	☐													
Session 3	☐	☐													
Session 4	☐	☐													
Session 5	☐	☐													
Session 6	☐	☐													
Session 7	☐	☐													
Session 8	☐	☐													
Session 9	☐	☐													
Session 10	☐	☐													

** A counselor-in-training (CIT) must be 15 years old at a day camp and 16 or 17 years old at an overnight camp. CITs that do not meet the minimum age requirements must be accounted for as a camper.

Camp Director

Name of Camp Director: _____ Date of Birth: ____/____/____

Education: _____

Qualifying Experience: _____

A "State Central Register Database Check" form (LDSS-3370) and a "Prospective Children's Camp Director Certified Statement" form (DOH-2271) must be completed by the Camp Director and submitted to the LHD with this form.

Camp Health Director

Name of Camp Health Director(s): _____

Attach additional sheets if more than one Health Director is used.

Qualifications (certification, licenses, etc.) ☐ Doctor ☐ Nurse Practitioner ☐ Physician Assistant ☐ RN ☐ LPN ☐ EMT ☐ Other _____

NYS License Number: _____ *For day camps only:* Will the Health Director be located on-site or off-site? ☐ On-site ☐ Off-site

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Health Director or Designated Assistant. (See Section 7-2.8 for requirements)

Certifications	Staff Possessing Certification		Course Provider	Course Title	Issue Date
CPR	☐ Health Director	☐ Assistant			/ /
First Aid	☐ Health Director	☐ Assistant			/ /

Aquatics Director

Name of Camp Aquatics Director: _____ Date of Birth: ____/____/____

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Aquatics Director. (See Section 7-2.5(e) for minimum qualifications)

Certifications	Course Provider	Course Title	Issue Date
Lifeguard Supervision and Management*			/ /
Lifeguarding			/ /
Progressive Swimming Instructor			/ /
CPR*			/ /
First Aid			/ /

* The Camp Aquatics Director must possess these certifications to qualify.

Aquatic Experience (check qualifying experience below)

- ☐ One season of previous experience as a camp aquatics director at a New York State children's camp.
- ☐ Two seasons of previous experience consisting cumulatively of at least 12 weeks as a children's camp lifeguard, as specified in Section 7-2.5(g), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.
- ☐ At least 18 weeks of previous experience as a lifeguard, as specified in Section 7-2.5(g)(2), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.

Other Staff Requirements

Subpart 7-2 of the New York State Sanitary Code (Children's Camps) specifies minimum staff ratios and qualifications for counselors, lifeguards, progressive swimming instructors, riflery instructors, and additional first aid and CPR certified staff. When staff are required to possess special certification, a course standard or criteria is specified in the regulation. Certification courses which have been reviewed and meet or exceed the Children's Camp Code standard/criteria, are listed on New York State Department of Health (NYSDOH) "fact sheets." The fact sheets are available from the LHD and at the NYSDOH's website at www.health.ny.gov. Camp operators are responsible for ensuring that required staff are present and possess acceptable certification. A LHD may require a children's camp operator to document staff ratios and qualifications by submitting a Children's Camp Additional Staff Qualifications form (DOH-367a) and/or copies of certification cards. Copies of all required certifications must be maintained on file at the camp.

Written Safety Plan, Facility Additions/Modifications, and Itinerary of Camp Trips

1. Written Safety Plan as required by Section 7-2.5(n)

- ☐ Plan attached
- ☐ Previously submitted on ____/____/____. This plan remains up to date and complete.
- ☐ Update to plan attached

2. Facility Addition/Modifications

Provide a list of additions or modification to the camp that have been made since last season or that are planned prior to this season. Include additions or modifications to buildings (cabins, kitchens, dining halls, infirmary, assembly areas, privies and toilets, etc.), potable water and sewage disposal systems, swimming pools, bathing beaches, activity areas (challenge course, archery and rifle ranges, etc.), emergency access and egress roads and any other camp facilities.

- ☐ List attached
- ☐ No Addition/Modifications
- ☐ Not Applicable. Camp did not operate last season.

3. Itinerary of Camp Trips

Attach a list of camp trips. Describe the activities that will take place (swimming, canoeing, hiking, etc.) and include the trip date(s) when known.

- ☐ List attached
- ☐ No trips

Section 7-2.5(p) requires a written statement or brochure outlining the rights and responsibilities of campers and camp operators to be provided to parents or guardians of campers by the camp operator with any enrollment application forms and/or enrollment contract forms. Either a statement or brochure prepared by the camp and approved by the permit-issuing official or the Department of Health brochure "Children's Camps in New York State" may be used. Please check the appropriate box below for the brochure sent with your application materials.

- ☐ A statement (brochure) which has been submitted to the DOH and approved
- ☐ "Children's Camps in New York State" Brochure (#3601)

I certify that the information given in this form is true.

Signature of Camp Operator: _____

Print Name: _____ Title: _____ Date: ____/____/____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Children's Camp Additional Staff Qualifications

Instructions:

Local health departments (LHD) may require children's camp operators to document staff ratios and qualifications by submitting this form and /or copies of certification cards. Complete the applicable items and submit this form for review as directed by the LHD that has jurisdiction in the county where the camp is located. Use additional sheets if necessary. Information that is not available should be identified as "Pending". For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available. Copies of all required certifications must be maintained on file at the camp. All code citations refer to Subpart 7-2 of the New York State Sanitary Code.

Facility Name:_____ Facility Code: _____
Date Open: __/__/__ Date Close: __/__/__

Progressive Swimming Instructor (PSI): Required for assessing camper swimming ability. Refer to Section 7-2.5(f).

Staff Name	Provider	Course Title	Issue Date
			/ /
			/ /
			/ /

Lifeguard Certification: Required for camps with swimming activities. Refer to Sections 7-2.5(g) and 7-2.11(a) for minimum qualifications and ratios.

See DOH fact sheets for acceptable certifications.	**Lifeguarding-** Certifications must be acceptable for the bathing facility type used.		**CPR–** Certification required for each Lifeguard. Certification may not exceed one year in duration.	
Staff Name and Date of Birth	**Provider / Course Title**	**Issue Date**	**Provider / Course Title**	**Issue Date**
/ /		/ /		/ /
/ /		/ /		/ /
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Additional First Aid and CPR Staff: Required for all camps as specified in Section 7-2.8.

See DOH fact sheets for acceptable certifications.	**First Aid** – A minimum of one staff for each 200 campers*		**CPR-** A minimum of one staff for each 200 campers.* Certification may not exceed one year in duration.	
Staff Name and Date of Birth	**Provider / Course Title**	**Issue Date**	**Provider / Course Title**	**Issue Date**
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
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*Trip and Activity Leaders may also require certification in First Aid and CPR depending on the activity and location. Refer to Sections 7-2.5(h) and 7-2.5(i).

Counselor Data: Required for all camps. List the number of counselors proposed for the camp session with the most campers. Refer to Sections 7-2.5 and 7-2.11 for counselor qualification and ratio requirements.

Staff Ages	**Counselors**	
	Male	**Female**
16 (Day camps only)		
17		
18 & Over		

Riflery Instructor: Required for all camps with riflery activities. Refer to Section 7-2.5(j).

Name: _____ Date of Birth: ___/___/___

Certification:_____ Date Issued: ___/___/___

I certify that the information given in this form is true.

Signature of the individual operator or official operating person:_____

Print Name:_____ Title:_____ Date:___/___/___

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Prospective Children's Camp Director Certified Statement

THIS STATEMENT IS RELATIVE TO CONVICTION OF A CRIME OR THE EXISTENCE OF A PENDING CRIMINAL ACTION.

Name (children's camp director) Date of Birth Mo / Day / Yr

Address STREET

CITY STATE ZIP

Have you ever been convicted of a crime (i.e., a misdemeanor or a felony) or do you presently have a criminal action pending against you? ☐ YES ☐ NO

If YES, for each such conviction or pending action provide the following information:

1. The date of the incident which resulted in the criminal conviction or charge: Mo / Day / Yr

2. The date of the conviction or charge: Mo / Day / Yr

3. The crime you were convicted of or are presently charged with:

4. The nature of the incident which resulted in the criminal conviction or charge:

5. The city, county and state you were convicted in or are presently charged in:
CITY COUNTY STATE

6. The name of the court you were convicted in or are presently charged in:

7. The penalties imposed as a result of the conviction (i.e., fine, jail term, restitution, etc.):

8. For each of the penalties imposed, list the date the penalty was complied with (i.e., date fine or restitution was paid in full, date jail term was completed, etc.):

Date(s) Of Fine	Restitution Paid in Full	Date(s) Jail Term Completed
Mo / Day / Yr	☐ Yes ☐ No	Mo / Day / Yr
Mo / Day / Yr	☐ Yes ☐ No	Mo / Day / Yr

I _____, certify under penalty of perjury that the above information
Print Name
is complete and accurate.

_____ Mo / Day / Yr
Signature of Children's Camp Director

Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: Must include street, city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA:

- **ALL** HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.
- Remember to **write clearly** or **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

If there are no other household members, indicate NONE on the line below "Maiden/Alias".

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: fill in either M (Male) or F (Female) for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant's address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated (mm/dd/yy). The SCR **will not accept** a form with a signature date more than 6 months old.

If you have questions regarding proper completion of this form, **please call the SCR at 518-474-5297.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 04/2009) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER **(Area Code):**

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category " box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
MAIDEN/ALIAS						

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE

APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE

SIGNATURE	DATE

AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons eighteen years old and over residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY AND GROUP FAMILY DAY CARE also must sign the form.

AGENCY CODE
Record your 3-digit agency code. **NOTE:** Day Care, Family and Group Family Day Care and Camps must provide the agency code of the agency or office which issues your license or certificate. Verify your Alpha or Alpha/Numeric 3 digit code with your licensing agency.

DAYCARE PROVIDERS
Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID (RID) number. (Contact your licensing agency/Regional Office if you have any questions).

RESOURCE I.D. (RID)
Record your RESOURCE I.D. (RID) in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs, and Local Departments of Social Services, have RID'S as of 9/01. Verify your RID with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.state.ny.us

CLEARANCE CATEGORIES
Record the appropriate category.

- **F** - Prospective/new employee other than day care employees. (fee required - see below)*
- **D** - Prospective employee (Local DSS district - bill against reimbursement)**
- **Y** - Prospective Day Care employee
- **Y** - Provider of goods/services
- **Y** - Applying to be a group family day care assistant.
- **Q** - Applying to be group family day care provider.
- **Z** - Prospective volunteer/consultant.
- **X** - Applying to be adoptive parents pursuant to an application pending before the inquiring agency.
- **W** - Applying to be foster parents or family care home providers.
- **R** - Applying to be kinship foster parents.
- **P** - Applying to be family day care provider.
- **N** - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.)
- **M** - Director of a summer camp, overnight camp, day camp or traveling day camp.
- **E** - Current employee.

AGENCY LIAISON
Record the name of the person to whom the response should be sent (**cannot be the same as applicant or related to the applicant**).

APPLICANT/HOUSEHOLD MEMBER AREA INSTRUCTIONS- This information is to be provided by the applicant/ employee/provider. See front of form.

APPLICANT (S) (at least one person must be so designated)-USE FIRST LINE

MAIDEN NAME/ALTERNATIVE/AKA: must be completed for every applicant. Record **ALL** previous names used. Start with second line. Use as many lines as needed (One last name per line)

OTHER HOUSEHOLD MEMBERS: describe relationship to applicant, e.g., son, daughter, father, mother, friend, etc. on remaining lines (ATTACH ADDITIONAL PAGE IF NECESSARY)

IF NO OTHER HOUSEHOLD MEMBERS, record NONE on line below MAIDEN/ALIAS.

*Social Service Law 424-a requires the collection of fees for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to "New York State Office of Children and Family Services" in the amount of five dollars, is to accompany the form. The check also is to include the applicant's name and the agency code.
N.B.: **a separate check must accompany each form.**

**Social Service Law 424-a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions regarding proper completion of this form, please call the SCR at 518-474-5297.

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480, Attention: Service Center Unit
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to:

THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144. If you have difficulty accessing a form on either site, you can call the automated forms hotline at 518-473-0971.

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

Department of Emergency Services
Office of Emergency Management

Camp Contact Form

If your Organization has multiple camps, please make copies of this form and provide separate information for each camp.

Camp Organization_____

Street Address_____

Town or Village_____

Camp telephone number_____

Camp e-mail address_____

Dates Camp is in session_____

Actual location of the Camp if different from mailing address
(include building number and street address) _____

Pre-Camp Season Contact Information

Contact_____

Address_____

Telephone_____

Cell phone_____

E-mail address_____

24-hour Contact Information (Camp Season)

Contact #1_____

Telephone_____

Cell phone_____

Pager_____

E-mail_____

Contact #2_____

Telephone_____

Cell phone_____

Pager_____

E-mail_____

Camp Statistics

Maximum number of children attending camp_____

Number of staff or faculty_____

Handicapped or special needs children_____

Transportation

Do you provide transportation for your campers? _____

Name of Bus Company_____

Bus Company contact_____

Bus Company phone number_____

Are buses stored at camp site during the day? _____

If not, estimated time to mobilize buses at camp_____

How long does it take to return all campers home (early dismissal)_____

Number of Private Camp Vehicle's available_____

Do you have day trips planned for your campers? _____

New York State Sanitary Code Chapter 1

Subpart 7-2.8(d) requires that:

The following injuries, illnesses, and incidents to campers and/or staff members are to be reported to the Department of Health within 24 hours (including evenings, weekends, and holidays).

Campers	**Staff**
Reportable Illnesses/Injuries	Reportable Illnesses/Injuries
1. Resuscitations (i.e. use of CPR)	1. Resuscitations (i.e. use of CPR)
2. **Admission**s to hospitals	2. **Admission**s to hospitals
3. All illnesses suspected of being water, food, or air-borne or spread by contact	3. All illnesses suspected of being water, food, or air-borne or spread by contact
4. Deaths	4. Deaths
5. Administration of epinephrine (i.e., Epi-pen) as a result of illness or injury	5. Administration of epinephrine (i.e., Epi-pen) as a result of illness or injury
6. Exposure to animal potentially infected with rabies.	6. Exposure to animal potentially infected with rabies.
7. **Referrals** for medical treatment of a hospital or other medical facility for: **eye**, **head**, **neck**, or **spine** injuries.	7. Not applicable for Staff
8. Second or third degree burns to 5% or more of the body.	8. Not applicable for Staff
9. Bone fractures and dislocations	9. Not applicable for Staff
10. Stitches	10. Not applicable for Staff
11. **Allegation**s of physical or sexual abuse.	11. Not applicable for Staff

3/2010

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
COMMUNICABLE DISEASE REPORTING REQUIREMENTS

Reporting of suspected or confirmed communicable diseases is mandated under the New York Sanitary Code (10NYCRR 2.10) and Westchester County Sanitary Code Article IV, Section 873.402. The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
(Animal bites for which rabies prophylaxis is given[1]
(Anthrax[2]
(Arboviral Infection[3]
Babesiosis
Botulism[2]
Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
(Cholera
Cryptosporidiosis
Cyclosporiasis
(Diptheria
E. coli 0157:H7 infection[4]
Ehrlichiosis
(Encephalitis
(Foodborne illness
Giardiasis
(Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
(Hantavirus Disease
Hemolytic uremic syndrome (HUS)
Hepatitis A
(Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant Hepatitis B carrier
Herpes Infection, infants age 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
(Measles
(Melioidosis[2]
Meningitis
Aseptic or viral
(Haemophilus
(Meningococcal
Other (specify type)
(Meningococcemia
(Monkeypox
Mumps
Pertussis
(Plague[2]
(Poliomyelitis
Psittacosis
(Q Fever[2]
(Rabies[1]
Rocky Mountain spotted fever
(Rubella (including congenital rubella sydrome)
Salmonellosis
(Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing infection[4]
Shigellosis[4]
(Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
(Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
(Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8]
Trichinosis
(Tuberculosis current disease (specify site)
(Tularemia[2]
Typhoid
Vibriosis[6]
(Vaccinia Disease[9]
(Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Name/Address: **Westchester County**
Department of Health – DC
145 Huguenot Street – 7th Floor
New Rochelle, New York 10801

Phone: **(914) 813-5159 [M-F 8:30-4:30]**
(914) 813-5000 [After Hours & Weekends]

Fax: **(914) 813-5182**

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- phone or fax diseases in bold type,
- mail case report, DOH-389, for all other diseases,
- in New York City use form PD-1

SPECIAL NOTES

- Diseases listed in **bold type (()** warrant prompt action and should be reported **immediately** to local heath departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form 395V.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies, and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable to:** Division of Epidemiology
  P.O. Box 2073, ESP Station
  Albany, New York 12220-2073
  (518) 474-4284
  In New York City: New York City Department of Health
  For HIV/AIDS reporting, call:
  (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterriorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test $\geq$ 1:16 or any positive primary or secondary stage disease or prenatal or delivery test result regardless of titer should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, Cases should be reported to the NYCDOHMH
9. Persons with vaccinia infection due to contact transmission, and persons with the following complications from vaccination: eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the vaccination site, and any other serious adverse events.

ADDITIONAL INFORMATION

Reporting Forms (DOH 389) are available for download at:
http://health.westchestergov.com/images/stories/pdfs/form_doh_389.pdf
For more information on disease reporting, call Westchester County Department of Health Division of Disease Control at (914) 813-5159, or New York State Department of Health Bureau of Communicable Disease Control at (518)-473-4439. In New York City 1(866) NYC-DOH1.

PLEASE POST THIS CONSPICUOUSLY

Rev. 04/14

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection
Children's Camp Program

Injury Report

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.

A. FACILITY INFORMATION

Camp Name:_____ Facility Code:____ _____ _____ ____ _____ _____

Camp Address: _____ Date Reported ____/___/____

B. EVENT INFORMATION

eHIPS Incident Number: _____ **(Note: Assigned by eHIPS)**

Date of Incident ____/___/___ Time of Occurrence ___: ____ (Military Time) Location where injury occurred: _____ a. In-Camp b. Out-of-Camp

Where did injury occur? _____ Specify locations marked with an asterisk: _____

a. Amusement park	e. Arts & crafts	i. Classroom	m. Horseback area/trail	q. Outdoor sports area	u. Recreational hall	y. Tenting/campsite area
b. Aquatic area*	f. Assembly area	j. Cookout area	n. Indoor sports area	r. Parking lot	v. Riflery area	z. Other*
c. Aquatic theme park	g. Bathroom/shower	k. Dining area	o. Kitchen area	s. Playground	w. Ropes/challenge course	
d. Archery area	h. Camp/trail/road	l. Drama/stage area	p. Open field/lawn*	t. Public highway/road	x. Sleeping area	

Note: For incidents with multiple victims, utilize this form for the event information and initial victim, complete section C-2 and attach form DOH-61b.

C. VICTIM INFORMATION: The shaded information is confidential and must be protected against unauthorized disclosure. For an incident with more than one victim, utilize this form for the incident and initial victim information and attach form DOH-61a for the additional victims.

1.

Name of Victim (Last, First, MI):_____ Name of Parent or Guardian (Last, First, MI):_____

Home Address:_____ Home Phone Number: (_____) _____-_____

eHIPS Victim ID Number:_____ (Note: assigned by eHIPS)

Age: _____ **Sex:** ❑ Female ❑ Male **Status:** ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor ❑ Other Staff* ❑ Other* Specify* _____

What was the victim doing? _____

a. Amusement park rides	h. Classroom instruction	o. Games-organized*	v. Playground equipment activity	dd. Swimming
b. Aquatic theme park rides	i. Cooking	p. Gymnastics	w. Playing	ee. Transportation
c. Archery	j. Dancing/Acting	q. High adventure activity	x. Riflery	ff. Travel between activities
d. Arts & crafts	k. Diving	r. Hiking	y. Rollerskating/rollerblading	gg. Walking/Running
e. Bicycling	l. Eating	s. Horseback riding	aa. Ropes/Challenge course	hh. Woodcarving/Wood working
f. Boating/Canoeing	m. Fighting	t. Martial arts	bb. Sleeping	ii. Woodcutting/chopping
g. Chores	n. Free period	u. Nature study/walk	cc. Sports*	z. Other *
				* Specify_____

2. Number of Victims
❑ Single Victim ❑ Multiple Victims (DOH-61h attached)

D. INJURY INFORMATION

- Report all camper and staff injuries which result in death or which require resuscitation or admission to a hospital; camper injuries to the eye, neck or spine which require referral to a hospital or other facility for medical treatment; camper injuries where the victim sustains second or third degree burns to five percent or more of the body; camper injuries which involve bone fracture or dislocations and camper lacerations requiring sutures. Enter the information for questions D-1, D-2 and D-3 in the table below. Up to FOUR injuries can be indicated per victim. To report injuries for additional victims of this incident, use form DOH-61h.

1. Type of Injury:

a. Bite	c. Concussion	e. Dislocation	g. Internal (organ damage)	i. Puncture	k. Suffocation/drowning
b. Burn	d. Cut	f. Fracture	h. Near drowning	j. Strain/Sprain	z. Other*(specify)

2. Area Injured:

a. Abdomen	d. Back	g. Eyes	j. Hand/finger	m. Knee	p. Respiratory System	s. Wrist
b. Ankle	e. Chest	h. Face	k. Head	n. Leg	q. Shoulder	z. Other *
c. Arm	f. Clavicle (collar bone)	i. Foot	l. Hip	o. Neck	r. Spine	

3. Cause of Injury:
   a. Bite from *
   b. Collision with *
   c. Contact with heat or flame
   d. Contact with sharp object
   e. Falling/Stumbling
   f. Motor vehicle accident
   g. Poisoned by *
   h. Struck by *
   i. Submersion
   z. Other *

	Type of Injury (question D1)	*Specify (when required)	Area of Injury (question D2)	*Specify (when required)	Cause of Injury (question D3)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

E. TREATMENT - For each person providing treatment, indicate in the below table the location and type of treatment that person provided. Up to FOUR treatment providers may be indicated. To report treatments for additional victims of this incident, use form DOH-61h.

1. Who Provided Treatment?
   a. Dentist
   b. Emergency Medical Technician
   c. First Aider*
   d. Licensed Practical Nurse
   e. Nurse Practitioner
   f. Physician
   g. Physician's Assistant
   h. Registered Nurse
   i. Victim
   z. Other*

2. Where was treatment provided?
   a. Camp infirmary b. Admitted to Hospital c. At site d. Dentist's Office e. Doctor's Office f. Emergency Clinic g. Emergency Room z. Other*

3. What Treatment was provided? (Indicate the primary treatment provided)
   a. Antibiotic
   b. Antihistamine/Decongestant
   c. Anti-inflammatory/analgesic
   d. Antiseptic
   e. Cast/Splint
   f. Diagnostic
   g. Epinephrine Administration
   h. Gastrointestinal (antacid, laxative)
   i. Psychotropics
   j. Resuscitation
   k. Supportive (bedrest, observation, physical therapy)
   l. Sutures,* Staples*, medical glue (indicate how many below)*
   z. Other*

	Who (question E1)	*Specify (when required)	Where (question E2)	*Specify (when required)	What (question E3)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

F. SUPERVISION AND CONTRIBUTING FACTORS

1. Supervision during incident (indicate as many as apply) _____ _____ _____ _____ Specify when marked with an asterisk _____
   a. Activity inadequately addressed in the written plan
   b. Activity not addressed in the written plan
   c. Camper orientation for activity not documented/received
   d. No staff present
   e. Quality of supervision adequate
   f. Quality of supervision inadequate
   g. Staff not trained/knowledgeable as per the written plan
   h. Staff orientation/training for activity not documented/received
   i. Supervision ratio inadequate
   j. Supervision ratio correct
   k. Written plan not followed
   z. Other *

2. Contributing Factors: (Indicate as many as apply) _____ _____ _____ _____ Specify contributing factors marked with an asterisk: _____
   a. Alcohol/Drug use
   b. Area/Equipment not safe
   c. Area/Equipment not maintained
   d. Area not approved for use
   e. Developmental disability
   f. Equipment not approved
   g. Horseplay
   h. Physical disability
   i. Pre-existing medical condition
   j. Required safety equipment not used/defective
   k. Topography
   l. Victim lacked necessary skill/ability
   m. Weather*
   n. None
   z. Other*

G. INVESTIGATION

Was an On-Site investigation conducted by the Local Health Department? Yes No Date of On-Site Investigation: ____/____/____

Did the Local Health Department conduct a telephone follow-up? Yes No Date of Follow-up: ____/____/____

H. NARRATIVE- When entering the narrative into eHIPS, do not include the full names of people involved with the incident. Use the first and last name initials or other similar code.

Attach a description of the incident. Pertinent host, environment and agent factors should be discussed for the pre-event, event and post-event stages of the incident. (See Environmental Health Manual technical reference ADM 3 for guidance on report writing and incident investigation.) When applicable, describe camper supervision including staff to camper ratios, visual and verbal communication capabilities between campers and staff, compliance with Subpart 7-2 and the camp written plan and recommendations for administrative action against the camp.

Information received by: _____ Title:_____ Report reviewed by: _____ Title: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection
Children's Camp Program

Illness and Outbreak Report

INSTRUCTIONS: See Environmental Health Manual Procedure CSFP-146 before completing this form.

A. FACILITY INFORMATION

Camp Name:_____ Facility Code:____ ____ ____ ____ ____ ____

Camp Address_____ Date Reported ____/___/____

B. EVENT INFORMATION **eHIPS Incident Number**: _____ **(Note: eHIPS will assign when entered into system)**

Type of Incident: ❑ Illness (single case) ❑ Illness Outbreak (multiple case)

Date of Incident/Onset ____/___/___ Time of Occurrence/Onset ____ :____ (Military time)

Note: For illness outbreak, utilize this form for the event information and initial victim, complete section C-2 and complete form DOH-61a.

C-1. VICTIM INFORMATION **Material in Shaded area is confidential** **eHIPS Victim ID Number:_____ (Note: eHIPS will assign when entered into system)**

Name of Victim (Last, First, MI):_____

Home Address:_____

Name of Parent or Guardian (Last, First, MI):_____ Home Phone Number: (_____) _____-_____

Note: All the above confidential information must be collected and maintained by LHD for appropriate investigation and follow-up.

Age: _____ **Sex**: ❑ Female ❑ Male **Status**: ❑ Camper ❑ Developmentally Disabled Camper ❑ CIT/Jr. Counselor ❑ Counselor ❑ Other Staff* ❑ Other* Specify_____

2. Victim Information- (Complete for illness outbreak and attach DOH61a)

Number of campers: male_____ female_____ **Number of staff:** male _____ female_____ **Number of others:** male _____ female_____

D. ILLNESS DESCRIPTION - Report camper and staff communicable diseases, outbreaks and illness requiring resuscitation, admission to a hospital, or resulting in death.

1. Characterize the Illness _____

a. Acute illness or disease*
b. Allergic reaction*
c. Anaphylactic shock*
d. Asthma attack
e. Cardiac
f. Chronic illness or disease*
g. Dental problem/infection
h. Eye infection
i. Gastrointestinal*
j. Mandated reportable communicable disease* (Part 2 10NYCRR)
k. Neurological
l. Parasitic*
m. Respiratory infection
n. Seizure disorder
z. Other*
* Specify_____

2. Is illness communicable? ❑ Yes ❑ No If yes, indicate suspected means of transmission. _____

a. Airborne b. Animal bite or contact c. Foodborne d. Insect bite e. Spread by person to person contact f. Waterborne z. Other* *Specify_____

E. TREATMENT - For each person providing treatment, indicate the location and type of treatment that person provided in the table below. Up to FOUR treatment providers may be indicated. Specify all selections marked with an asterisk.

1. Who Provided Treatment?

a. Dentist
b. Emergency Medical Technician
c. First Aider*
d. Licensed Practical Nurse
e. Nurse Practitioner
f. Physician
g. Physician's Assistant
h. Registered Nurse
i. Victim
z. Other*

2. Where was treatment provided?

a. At Camp infirmary b. Admitted to Hospital c. At site d. Dentist's Office e. Doctor's Office f. Emergency Clinic g. Emergency Room z. Other*

3. What Treatment was provided? (Indicate as many as apply)

a. Antibiotic
b. Antihistamine/Decongestant
c. Anti-inflammatory/analgesic
d. Antiseptic
e. Cast/Splint
f. Diagnostic
g. Epinephrine Administration
h. Gastrointestinal (antacid, laxative)
i. Psychotropics
j. Resuscitation
k. Supportive (bedrest, observation, physical therapy)
l. Sutures,* Staples*, medical glue (indicate how many below)*
z. Other*

	Who (Question E1)	*Specify (when required)	Where (Question E2)	*Specify (when required)	What (Question E3)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

F. INVESTIGATION

Was an On-Site investigation conducted by the Local Health Department? Yes No Date of On-Site Investigation: ____/____/____

Did the Local Health Department conduct a telephone follow-up? Yes No Date of Follow-up: ____/____/____

G. NARRATIVE- When entering the narrative into eHIPS, do not include the full names of people involved with the incident. Use the first and last name initials or other similar code.

Provide a description of the illness. Include details of onset, treatment and resolution (returned to camp or went home). For foodborne outbreak investigations, follow Environmental Health Manual Procedure 803 in addition to completing this report.

Information received by: _____ Title: _____

Report reviewed by: _____ Title: _____

Department of Health

Camp Director's Self-Inspection Program

Dear Camp Operator:

In accordance with Subpart 7-2 of the New York State Sanitary Code and an acceptable evaluation by the Westchester County Health Department, your camp qualifies for conducting its own preseason inspection. You are being allowed to inspect your own facility using as a guide the enclosed document entitled, "Children's Camp Inspection Report, DOH-1315".

When you have completed the inspection and remedied any identified hazards that could jeopardize the health and safety of campers or staff, execute and return to the address shown below the, "Certification of Self-Inspection" form. The DOH-1315 should be signed, kept on file at the camp, and be available for inspection during the upcoming season.

The Self-Inspection Program enables the camp operator to review the camp's facilities during the pre-season in lieu of the Health Department's doing so. Upon receipt of the certificate stating that there are no unsafe or unhealthy conditions existing, the Westchester County Department of Health will then only, conduct operational inspections this season.

Please return the completed form, "Certification of Self-Inspection", with our application to:

Westchester County Health Department
BPHP
Mt. Kisco District Office
25 Moore Avenue
Mt. Kisco, NY 10549
(914) 864-7330

Rev. 3/16

Department of Health

Certification of Self-Inspection of a Children's Camp
As specified by section 10NYCRR 7-2.(d)(2)(ii)

I, _____operator of
(Print name of operator)

_____located at
(Name of Camp)

_____certify
(Address of Camp)

Under penalty of perjury that I have inspected my camp on _____
(date of inspection)

and the camp conforms or will be in conformance with Subpart 7-2 of the State Sanitary Code at the time of operation and it will not present a danger to the health, safety and welfare of the Camp occupants.

Camp Operator's Signature_____ Date_____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Children's Camp Inspection Report

A Review of Compliance with Subpart 7-2 of the New York State Sanitary Code

Facility Code	Facility Name	Address	Operator's Name

Capacity	Operation Name	Time Began	Time Ended

Office | Operation ID: | Date of Service: Month | Day | Year | Inspector's ID | Time spent conducting service: hr hr min min

Service Type: INSPECTION ○ REINSPECTION ○ PRE-OPERATIONAL ○ COMPLAINT ○ FIELD VISIT ○ INCIDENT ○ ILLNESS ○

Number of Red Violations Found | Total Red Violations Not Corrected | Number of Blue Violations Found | Reinspection Required ○ Yes ○ No

Future Service (Office Use Only):

Reinspection ○ Field Visit ○ Sampling ○ Meeting ○ Date: Month | Day | Year | Service By (Inspector ID):

PUBLIC HEALTH HAZARDS

○	Supervision - Staff Qualifications, Ratios; Children Protected from Unreasonable Risk; Visual Verbal Communication Provided	1
○	Safety Plan Implementation	2
○	Water Supply - Approved Source, Adequate Protection, Treatment, Quality, Quantity	3
○	Sewage System - No Children or Food Exposure; Water Supply or Bathing Beach Contamination	4
○	Safety Plan Medical Requirements Supervised by Health Director; Developmentally Disabled Camper Medication Administered by Qualified Staff	5
○	Transportation - Truck and Trailer Bed Transportation Prohibited; Counselor Supervision in Vehicles	6
○	Swimming - Adequate Supervision, Approved Locations, Safety Equipment, Depth Markings, Diving, Buddy System and Board System, Non-Swimmer Depth Restriction	7
○	Incidental Water Immersion - Trip Leader, Safe Depth and Flow Conditions, Procedures Specified, Area Tested	8
○	Waterfront/Boating - Personal Flotation Device Usage	9
○	Riflery/Archery - Adequate Range/Supervision	10
○	Horseback Riding - Adequate Equipment/Supervision	11
○	Fire Safety - No Overcrowding; Exits, Alarm Systems and Fire Fighting Equipment Provided and Maintained	12
○	Adequate Installation of Heat Producing Equipment; Storage of Flammable and Toxic Substances	13
○	Other Violations Deemed a Public Health Hazard by the Permit Issuing Official	14

ADMINISTRATION/SUPERVISION

○	Personnel - Qualified Director, Counselors and Counselors-In-Training; Staff Training-Provided, Documented, Individual Disabled Camper Needs	15
○	Adequate Supervision - Visual and/or Verbal Communication Capability, Accountability System	16
○	Personnel Records, Resumes on File; Communicable Disease Carrier; Criminal Justice Service Check	17
○	Valid Permit; Application; Enrollment Statement/Brochure	18
○	Safety Plan - Complete, On File, Updated, Implemented	19

SEWAGE

○	Facilities Provided, Maintained, No Sewage on Ground; Modifications/Additions Approved	20

SHOWERS/TOILETS

○	Showers-Provided, Constructed/Maintained, Plans Approved, Ratios, Water Temperature	21
○	Toilets, Privies, Lavatories-Provided, Constructed/Maintained, Ratios	22

POTABLE WATER

For Inspection of On-site Public Water systems, Complete DOH-4234 and Boxes 24, 29 and 30. For Individual Onsite Water System Inspections, Complete this Entire Section. DOH-4234 Completed? Yes ☐ N/A ☐

○	Sources Properly Developed and Protected	23
○	Treatment - Adequate, Maintained, Cl Residual _____ ppm	24
○	Adequate Water Quantity and Pressure	25
○	Free of Apparent Cross Connections; Drinking Fountains	26
○	Modifications/Additions Approved	27
○	Operation Records Maintained and Submitted	28
○	Annual Start-Up Procedure Completed	29
○	Water Quality Monitoring Performed	30

MEDICAL

○	Health Personnel - Qualified Health Director, First Aid and CPR Certified Staff; Ratios Met	31
○	Camper Medical History Provided; Medical Log Maintained; Injuries/Illness Reported; Emergency Contact Information; Modified Diets; Restrictions	32
○	Infirmary/Holding Area Provided; Medical Supplies	33

HOUSING

○	Maintenance - Safe, Adequate Size, Cleanable, Watertight, Roof and Sides; Lighting; Ventilation; Winter Building Heated	34
○	Mattresses and Linen (When Provided) Clean and Good Condition; Clearance: Above Bed, Between Heads of Beds; Bunk Beds: Two Levels, Adequate Guardrails	35
○	Floor Area, Overcrowding; Supervision; Wall and Ceiling Height; Non-Ambulatory Camper Housing - Adequate Ramps; Ground Floor Only	36

SWIMMING

For Inspection of On-site Bathing Facilities, Complete DOH-1321 for Pools and DOH-1322 for Beaches. Additional form(s) Completed? Yes ☐ No ☐

○	Aquatic Director; Lifeguards, Progressive Swimming Instructor, Counselor-Qualified; Ratio, Duties	37
○	Approved Locations; Controlled Access; Lighting	38
○	Buddy System/Checks; Board/Other System; Swim Ability Assessment; Triples; Lost Swimmer Plan	39
○	Non-Swimmers Identified and Restricted to Less Than Chest Deep Water; Areas Designated	40
○	Camps for Developmentally Disabled Campers-Parental Permission; Staff Ratios; Emergency Procedures/Drills	41
○	Trip Swimming - Safety Plan; Acceptable Location; Parental Permission; Lifeguard Ratio/Area; Buddy/Board System; Triples; Non-Swimmer Identification/Restriction	42
○	Wilderness Swimming - Safety Plan; Parental Permission; Supervision; Environmental Conditions; Buddy/Board System, Triples, Non-Swimmer Requirements, Equipment, Rules	43

RECREATIONAL SAFETY

○	Special Waterfront Activities - Lifejackets Used; Supervision; Safety Plan; Boats Registered	44
○	Riflery - Qualified Instructor; Camper Age; Supervision: Range Location, Firing and Ready Lines, Backstop, Signs, Flags; Rifles/Equipment Maintenance and Storage	45
○	Archery - Range Location, Marked Clearances, Firing and Ready Lines; Equipment Storage; Camper Supervision and Staff Training	46
○	Horseback Riding - Headgear, Stirrups/Shoes; Supervision, Skill Assessment; Animals-Disease Free, Compliance with DEC, A&M Laws	47
○	Equipment - Personal Weapons Restricted; Equipment Hazard Free; Activities Handicapped Accessible	48
○	On-site Activities - Activity Leader, First Aid, CPR; Counselor Ratios, Passive Activities	49
○	Camp Trips - Trip Leader, First Aid, CPR; Counselor Ratios, Safety Plan Review	50
○	Incidental Water Immersion - Safety plan, Water Depth Restriction, Trip/Activity Leader Familiar with Water Flow Characteristics	51

CONSTRUCTION/ELECTRICAL & FIRE SAFETY

○	Construction - State and Local Laws Compliance Statement; Permit-Issuing Official Notification	52
○	Building Standards; Electrical Safety; Tents Flame Retardant	53
○	Fire/Smoke Alarm System - Equipment Installed and Maintained; Fire Drills and Log	54
○	Exits; Unobstructed, Protected, Number, Dead Ends, Assembly Areas; Fires Reported	55
○	Exit Direction Signs; Emergency Lighting	56
○	Heating Sources - Installed; Maintained	57
○	Flammable Liquids: Labeled; Stored	58
○	Fire Fighting Equipment - Acceptable, Provided, Inspected, Placement, Maintained	59

FOOD

For Inspection of On-site Food Services, Complete DOH-192. DOH-192 Completed? Yes ☐ No ☐

○	Food Quantity/Quality Sufficient	60

GENERAL

○	Surface Drainage; Pesticides and Toxic Chemicals Use and Storage; Exterior Paths Appropriately Surfaced and Maintained	61
○	Insect, Rodent, Bat and Weed Control	62
○	Refuse-Storage, Handling and Disposal; Maintained	63
○	Transportation: Truck/Trailer Bed Occupancy Prohibited; Driver; Inspection; Seat Belts Used; Capacity Not Exceeded; Tools; Supervision	64

Inspection By (Signature) | Report Received by | Date

11471

DOH-1315 (02/07)

CHILDREN'S CAMP PROGRAM

REQUIRED REPORTING FOR INJURY AND ILLNESS

Children's camp operators must notify the local health department within 24 hours of the following occurrences:

- **Camper and staff injuries or illnesses which result in death or require resuscitation, admission to a hospital or the administration of epinephrine.**
- **Camper or staff exposures to animals potentially infected with rabies.**
- **Camper injuries to the eye, head, neck or spine which require referral to a hospital or other facility for medical treatment.**
- **Injuries where the camper sustains second or third degree burns to 5 percent or more of the body.**
- **Camper injuries that involve bone fractures or dislocations.**
- **Lacerations sustained by a camper which require sutures, staples or medical glue.**
- **Camper physical or sexual abuse allegations.**
- **Camper and staff illnesses suspected of being water-, food- or air-borne or spread by contact.**

Contact the local health department at (914) 813 –5000 between 8:30 a.m. and 4 :30 p.m. weekdays, or call (914) 813 –5000 after hours, weekends and holidays.

Children's Camps
Amusement Device Survey

Complete this survey for each amusement device at your children's camp. Amusement devices are defined in Part 45 of the Department of Labor (DOL) regulations and include: carnival rides; go-carts; bumper boats; water slides (with a vertical drop of 20 feet or more); climbing walls with mechanical belays; challenge courses; zip lines; and giant swings. **Please return the survey by May 15, 2018 via mail or fax to WCHD-BPHP, Mount Kisco Central Office, 25 Moore Avenue, Mount Kisco, NY 10549 / FAX: 914-813-4281.**

Camp Name: _____ County: __WESTCHESTER___

❑ **No amusement devices available at the camp.**

Amusement Device Type/Name List rope or challenge course elements separately. For devices other than challenge courses elements which are constructed on-site, provide the product manufacturer and serial number.	**Number Available**	**Amount of Liability Insurance Coverage**	**DOL Permit (Yes/No)**

Name of Person Completing Form: _____ **Telephone Number**:_____