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

Application for a Permit to Operate

GENERAL INSTRUCTIONS

Complete all items that apply to your establishment.
All applicants must complete sections A, B, G, & H. If you have any questions, contact the local health department that issues your permit.

SECTION A: Facility Information

Facility Name, Facility Address, Telephone Number, Fax Number and Municipality: Self explanatory

Capacity

A. Food services: enter actual seating capacity, or enter 00 for take out only.
B. Recreational vehicle parks, campsites, agricultural fairgrounds and mobile home parks: enter the number of actual sites.
C. Children's camp: enter the maximum number of campers the camp is approved for at one time.
D. Temporary residences and migrant farmworker labor camps, swimming pools, bathing beaches, mass gatherings: enter the maximum number of people the facility is approved to hold.
E. Recreational aquatic spray ground: enter 00.
F. Tanning Facility: enter the total number of tanning devices.

Facility Status: Check either profit or nonprofit. If nonprofit, submission of documentation (incorporation paper) verifying status may be required.

Facility Type: From the list below enter the facility type that best describes the main or primary operation of the facility. Some multiple operation facilities may require submission of separate permit application(s). Please consult the health department that issues your permit with any questions.

Facility Types:

Agricultural Fairgrounds
Bathing Beaches
- Freshwater River
- Impoundment/Pond
- Lake
- Ocean Surf
- Other Saltwater

Campground/Recreational Vehicle Park
Children's Camps
- Day Camp
- Day Camp – Developmentally Disabled
- Day Camp – Municipal
- Day Camp – Traveling
- Overnight Camp
- Overnight Camp – Developmentally Disabled
- Overnight Camp - Municipal

Food Service Establishment
- Restaurant
- Caterer
- School
- Institution
- State Office for the Aging (SOFA) – Prep Site
- State Office for the Aging (SOFA) – Satellite Site
- Summer Feeding Program (USDA) – Prep Site
- Summer Feeding Program (USDA) – Satellite Site

Mass Gathering
Migrant Farm Worker Housing
- Farm Labor Housing

Mobile Home Parks
Mobile Food
Recreational Aquatic Spray Grounds
- Indoor
- Outdoor

Swimming Pools
- Indoor
- Outdoor
- Indoor/Outdoor
- Wave Pool – Indoor
- Wave Pool – Outdoor
- Wave Pool – Indoor/Outdoor
- Aquatic Amusement – Indoor
- Aquatic Amusement – Outdoor
- Aquatic Amusement – Indoor/Outdoor
- Spa

Tanning Facility
Temporary Food

Temporary Residences
- Labor Camps other than Migrant
- Interior Corridor – Single Story
- Interior Corridor – Two Story
- Interior Corridor – Three Story
- Interior Corridor – Four or more Story
- Exterior Corridor – Single Story
- Exterior Corridor – Two Story
- Exterior Corridor – Three Story
- Exterior Corridor – Four or more Story
- Cabin or Bungalow Colony

Vending Food Machines
State Agency Licensed Facilities
- State Licensed Inspected Facility
- State Owned Operated Facility
- Day Care Center – Residential
- Day Care Center – Non-Residential

Water Supply/Sewage System: Check “public” if the facility is serviced by a municipal or public system. Check “private” (onsite) if the system(s) and its operation is onsite and only for this facility. A water/sewage system that is commonly used by several establishments (i.e.: a mall operation) would be a public system.

Operations under this registration: Provide the number of specific operations that apply to this registration. Complete even if the primary or main operation of the facility was identified under the facility type. A swimming complex with one spa, one beach, one indoor and two outdoor pools would report a facility type swimming pool-indoor and enter 1 for spa, 1 for bathing beach, 1 for indoor pool and 2 for outdoor pools in the operations under this registration Section A. For tanning facilities enter the number of beds and booths. Some facilities with multiple operations require separate applications, (i.e., a food service operated at a swimming pool complex would require a separate swimming pool and food service application, and would report their specific operations on the appropriate application forms).

Expected Opening/Closing Date: Enter the expected opening and closing dates (i.e., June 1 is 06/01). If the operation is year-round, enter 01/01 for opening and 12/31 for closing.

Days of Operation: Check each box for the day(s) the facility will be open under routine operation.

Hours of Operation: Enter the hour the facility is expected to open and close under routine operation. Circle AM or PM as appropriate.

SECTION B: Operator/Owner Information

Name of Legal Operator or Operating Corporation (Person in Charge): Enter name of the legal entity that operates the facility. If the facility is operated by a corporation, enter the name of the operating corporation and the name of the person in charge of the day to day operation. Provide the name(s) of the corporate officers/partners in Section F.

Permanent Address of Operator and Telephone Number: Enter the mailing address including street, city, state and zip code where the legal operator wants to receive mailed correspondence. Enter the telephone and fax number of the legal operator.

Employer Identification/Social Security Number: Enter the **Employer Identification or Social Security Number** of the operator of the facility.

Email Address and Fax No.: Enter the email address and fax no. where important health and safety alert messages should be sent during an emergency.

Name of Owner: Enter the name of the owner of the facility if different from the operator.

Permanent Address of Owner and Telephone Number: Enter the mailing address and telephone number of the owner if different from the operator.

SECTION C: Complete only for temporary food service establishments, regulated under Subpart 14-2 NYSSC

SECTION D: Complete only for mobile food service vehicles or pushcarts, regulated under Subpart 14-4 NYSSC

Check the appropriate type of unit. If motorized, provide the license plate number. Provide the name and address of the commissary where the food is prepared. Attach a separate list of the types of food(s) and/or beverages to be served.

SECTION E: Complete only for food/beverage vending machines, regulated under Subpart 14-5 NYSSC

Attach a list of the number and type of food dispensing machines including the address and telephone number of each site under this permit.

SECTION F: Partners and Corporation Officers

If a facility is operated by a partnership or corporation, provide the name, title, permanent mailing address and telephone number of all corporate officers or partners involved in the operation or ownership of the facility.

SECTION G: Workers' Compensation and Disability Insurance

Provide copies of appropriate forms documenting compliance with the Worker's Compensation Law for (1) both Workers' Compensation and New York State Disability Insurance coverage, **or** (2) exemption from coverage.

SECTION H: Signature

Provide the signature of the individual operator, a corporate officer or other authorized identified official in Section F. Please print the name, title and date in the space provided. **Failure to sign the form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code and is punishable by fines.**

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

Application for a Permit to Operate

Complete all items that apply to your establishment (all applicants must complete Sections A, B, G and H), sign on the back page and return with the appropriate fee at least 30 days prior to the expected opening date to:

SECTION A: Facility Information (Entire section must be completed by all applicants.)

Facility name _____

Facility address _____

City _____State _____ Zip _____ Telephone no. (___)_____ Fax no. (___)_____

Municipality _____ [T] [V] [C] Capacity [_____] Facility Status [ ] Profit [ ] Non-profit

Facility Type [_____] Indicate days operation is open S M T W T F S

Expected opening date [__|__|__|__] Month/Day Expected closing date [__|__|__|__] Month/Day Hours of operation [__|__|__|__] Open AM PM [__|__|__|__] Close AM PM

Water Supply

[__] Public (municipal)

[__] Private (onsite)

Sewage System

[__] Public (municipal)

[__] Private (onsite)

Number of operations under this registration

[___] Indoor Pools [___] Bathing Beaches [___] Food Services [___] Day Camps

[___] Outdoor Pools [___] Spa Pools [___] Recreational Aquatic Spray Grounds

[___] Tanning Devices

SECTION B: Operator/Owner Information (Entire section must be completed by all applicants.)

Legal **operator** or operating corporation _____
(If corporation or partnership, Section F must be completed.)

Person in charge _____ Telephone no. (___)_____ Fax no. (___)_____

Permanent address _____ Email address _____

City _____ State _____ Zip _____ Employee Identification Number [___] [___] [___][___][___][___][___][___][___]

Or Social Security Number [___][___][___]-[___][___]-[___][___][___][___]

Owner _____ Telephone (___)_____

Permanent address _____ City _____ State _____ Zip _____

SECTION C: Complete for temporary food service establishments only (attach additional sheets as necessary).

Name and location of event _____

Name of Foods	Supplier of ingredients	Where and how foods will be prepared and served

SECTION D: Complete for mobile food service establishments or pushcarts only.

Type of vehicle [__] Motorized [__] Pushcart [__] Other (specify) _____

Motor vehicle license number (motorized vehicles only) _____

Commissary name _____ Telephone No. (___) _____

Address _____ City _____ ___ State _____ Zip _____

List on a separate sheet of paper the type of food and beverages served.

SECTION E: Food and beverage machines only. Attach a list of all machine locations and food dispensed.

SECTION F: Partners and Corporate Officers

List all partners and corporate officers in the operation of the facility. Include vice president(s), secretary, treasurer. Attach DOH-2135 (or additional sheets) as necessary.

Name	Title	Address	Telephone No.

SECTION G: Workers' Compensation and Disability Insurance (All applicants must complete this section.)

Check the appropriate lines and submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law:

A. Workers Compensation and Disability Insurance Coverage **Provided**

Workers Compensation

[__] Form C-105.2 – Certificate of Worker's Compensation Insurance **OR**

[__] Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

[__] FormSI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

[__] GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

AND

Disability Insurance

[__] DB-120.1 - Certificate of Disability Benefits **OR**

[__] Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage **NOT Provided**

[__] Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

SECTION H: Signature (Entire section must be completed by all applicants.)

FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW.

Failure to sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code.

Signature of individual operator or authorized official _____

Print name of person signing _____ Title _____ Date _____

SECTION I: FOR OFFICE USE ONLY

Permit issuance recommended? [__] Yes [__] No Permit Effective Date [___][___][___] Permit Expiration Date [___][___][___]
Conditions of approval

Signature _____ Title _____ Date _____

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

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.

LDSS-3370 (Rev. 04/2009)

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

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: _____

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.