NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 7, 2015

Re: Children's Camp Application - 2015

Dear Camp Operator,

Enclosed are the forms necessary for submission to receive a 2015 Permit to Operate. Please complete and return all applicable forms, and include a check made payable to the New York State Department of Health (if applicable), to the Glens Falls District Office (GFDO), **at least 60 days** prior to opening day. Additional copies of some of the required forms can be found on the department website at http://www.nyhealth.gov/environmental/outdoors/camps/. The following documents must be received in order for an application to be considered complete:

- Permit Application (DOH-3965)
- Fee Schedule (DOH-2225F)
- Proof of Workers' Compensation and Disability Insurance coverage, or a signed form of attestation (CE-200) that coverage is not required (original signature only) **(Please refer to the enclosed fact sheet)**
- Children's Camp Facility and Staff Description (DOH-367) **(This form has been modified starting in 2012)**
- Children's Camp Additional Staff Qualifications (DOH-367a) **(May be submitted upon confirmation of proposed staff. Please send as soon as completed.)**
- Children's Camp Director Certified Statement (DOH-2271)
- State Central Register Database Check (LDSS-3370) **(Please fill-out completely and return to Glens Falls District Office, not to DSS.)**
- Updated Safety Plan ***or***
- Up to Date Affirmation Statement (located on Page 2 of the DOH-367 form.) **(Please contact this office for information regarding submission of a Safety Plan Addendum, if needed. This must be completed only if there are changes or additions to the camp or any activities).**
- Children's Camp Inspection Report (DOH-1315) **(Please complete and return as a self-inspection document.)**

As a reminder, out-of-camp trips are considered part of the camps written safety plan, and as such, proposed trip plans must be submitted to this office for review and approval. You are not required to re-submit trip plans for out-of-camp trips which have been previously reviewed and approved by this office.

All children's camp staff, including volunteers must be screened through the NYS Division of Criminal Justice Sex Offender Registry (do not forward to this office). This is a New York State Sanitary Code (NYSSC) requirement. Searches of 30 or more must be completed electronically. You must retain a copy of proof of screening on-site, as this is an inspection item.

Fact Sheets (enclosed) are also available on the Department's website. Current staff qualification fact sheet are dated February 2015. Department staff are currently reviewing

available courses and vetting the curriculum offered to verify which courses meet the state's minimum training requirements. The current version of the fact sheets supersedes all previous versions.

As an additional reminder, certain injuries and illnesses, physical or sexual abuse allegations, fires, and all potential rabies exposures or administration of epinephrine **must be reported to NYSDOH within 24 hours.**

Also, please be advised that if you designate staff, other than a licensed health care practitioner, to possess an on-site epinephrine auto-injector, there are additional requirements. These include staff passing an approved training course, filing a signed written agreement between the camp and the emergency health care provider, including this as part of your approved safety plan, and filing a notice of intent with the Regional Medical Services Council. Please call for additional information and paperwork, if needed. These requirements do not preclude a camper or staff member from attending camp with a properly **prescribed** epinephrine auto-injector.

The department website also provides these useful documents for your review and use:

- Children's Camps in New York State brochure
- Required Reporting for Injury Illness poster
- Children's Camp Program Wilderness Swimming Guidance
- Wilderness Swimming Site Field Assessment Tool
- Children's Camp Swimming Fact Sheet
- Procedures for Handling Outbreaks at Camps
- Meningococcal Disease Fact Sheet, with sample camp parent letter and parental response form **(now required at some camps; please refer to Subpart 7-2 for further details)**

General information regarding the prevention and control of bed bugs, including links to Cornell University and CDC, has been posted to the Department's website (http://www.nyhealth.gov/environmental/pests/bedbugs.htm). Bed bugs feed on blood but are not known to spread any disease to humans. Bites can cause allergic reactions or secondary infections in some individuals. If a bed bug infestation occurs at a camp, the operator must take corrective actions. An integrated pest management approach is recommended and if pesticides are used, they must be applied by a New York State licensed commercial applicator. A list of businesses offering commercial application of pesticides is available on the Department of Environmental Conservation (DEC) website at www.dec.ny.gov/permits/209.html.

This office has encountered sporadic incidences of Methicillin-resistant *Staphylococcus aureus* (MRSA) in recent years. We ask that you have medical staff review the Health Advisory: Prevention and Control of Methicillin-resistant *Staphylococcus aureus* located on the department's website. Additionally, education should be provided to all incoming staff regarding the detection of suspected incidences of MRSA, in order to allow the early diagnoses and treatment of cases. Both campers and staff should be reminded of the potential hazards associated with the sharing of personal hygiene products, clothing, and towels.

The most commonly cited violation continues to be inadequate supervision of campers. Please reaffirm with your staff the importance of quality supervision, and the requirement under Subpart 7-2 to meet specific supervision ratios at all times, and for every specific activity. Your Camp Written Safety Plan can assist in providing guidance, and should be used as the primary reference for your facility for all questions regarding the operation of your camp. As such,

please make available applicable sections of the safety plan to all staff and ensure at least one complete copy of the written safety plan is kept at the facility at all times. If you wish to update or modify the written safety plan, you must submit the revisions to this office for review and approval **prior to implementing the proposed changes.**

On June 30, 2013, legislation creating the New York State Justice Center for the Protection of People with Special Needs became effective. This legislation contains requirements for children's camps for children with developmental disabilities and requires amendments to the children's camp regulation (Subpart 7-2). The amendments apply to camps with 20% or more campers with a developmental disability and include new requirements for:

- staff screening and training and
- incident reporting/management.

Camps with programs affected by this legislations, or are thinking of expanding their programs into special needs operations, are strongly urged to contact the Justice Center for more information.

Updated copies of Subpart 7-2 (Children's Camp) of the NYSSC can be found on the department's website at http://www.nyhealth.gov/environmental/outdoors/camps. If you have any questions, please feel free to contact this office at (518) 793-3893.

Sincerely,

Gregory F. Reynolds
Principal Sanitarian
NYSDOH – Glens Falls District Office
77 Mohican St.
Glens Falls, NY 12801
(518) 793-3893
Fax (518) 793-0427

enclosures

cc: A. Gabalski, District Director
GFDO Sanitarians
File

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Permit to Operate Renewal Application

State of New York Department of Health

Business / Location Information (Please modify only if information has changed.)

Business Name: CAMP SARADAC SARATOGA SUMMER REC PRG — **Facility Code: 45-B146**

Address: 15 VANDERBILT AVENUE
SARATOGA SPRINGS, NY 12866

Business Phone: (518) 587-3550 x2300
Business Fax: (518) 584-1748
Business Website: www.saratoga-springs.org

Location: City of SARATOGA SPGS.

County: SARATOGA

Mail To:
CITY OF SARATOGA SPRINGS
RECREATION DEPARTMENT
15 VANDERBILT AVENUE
SARATOGA SPRINGS, NY 12866-4914

Permit Number *45-B146*

Permit Expiration Date *August 16, 2014*

Fee Exempt

Permitted Operation

CAMP SARADAC SARATOGA SUMMER REC PROGRAM — **Operation ID: 329421**

Children's Camp - Day Camp

In Operation: ○ Year-Round ● Seasonal — **If Seasonal:** Expected Opening Date 6/29 (Month/Day) Expected Closing Date 8/15 (Month/Day)

Capacity: 350 Persons — Days/Hours of Operation: 7:30am - 6:00pm

Permit Applicant Information (Please modify only if information has changed.)

Legal Operator or Operating Corporation: CITY OF SARATOGA SPRINGS

Person in Charge: Title — First: JOHN — M.I. — Last: HIRLIMAN

Address: RECREATION DEPARTMENT — 15 VANDERBILT AVENUE

City, State, Zip: SARATOGA SPRINGS — NY — 12866-4914

Primary Phone: (518) 587-3550 Ext 2306 ☐ Cell — Fax: (518) 584-1748 — Emergency Contact ☐

Other Phone: ( ) - Ext ☐ Cell — E-mail: john.hirliman@saratoga-springs.org

Location Owner: CITY OF SARATOGA SPRINGS

Address: RECREATION DEPARTMENT — 15 VANDERBILT AVENUE

City, State, Zip: SARATOGA SPRINGS — NY — 12866-4914

Primary Phone: (518) 587-3550 Ext 2306 ☐ Cell — Fax: (518) 584-1748 — Emergency Contact ☐

Other Phone: ( ) - Ext ☐ Cell — E-mail: john.hirliman@saratoga-springs.org

Permit to Operate
Renewal Application

State of New York Department of Health

Workers' Compensation and Disability Insurance

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 is PROVIDED

Workers Compensation

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

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

Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

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

AND

Disability Benefits

DB-120.1 - Certificate of Disability Benefits **OR**

Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage is NOT PROVIDED

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

Return Completed Application

Please return completed application to:

Make checks payable to "State of New York Department of Health" and include the permit number.

State of New York Department of Health
Glens Falls District Office
77 Mohican Street
Glens Falls NY 12801-4429

(518) 793-3893 Fax: (518) 793-0427
gdfocal@notes.health.state.ny.us

Signature of Individual Operator or Authorized Official (Entire section must be completed by all applicants.)

I would like to receive information and official correspondence related to this permit at the email address below: (Yes X No _)

john.hirliman @ saratoga-springs.org

"Operation without a valid permit is a violation of New York State Law and/or State Sanitary Code."

Signature _____

Print Name Joanne D. Yepsen Title Mayor Date 4/21/15

FOR OFFICE USE ONLY

Permit issuance recommended? ☑ Yes ☐ No Permit Effective Date _____ Permit Expiration Date _____

Conditions of approval _____

Signature _____ Title _____ Date _____

Migrant Labor Camps and Children's Camps
Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH

As required by Article 6, PHL, effective 1/1/88

Fee Exemption Requested? [x] Yes If Yes, complete sections A, C and D below and return. [ ] No

FOR OFFICE USE ONLY

Cashline #

Amount $

Received by

INSTRUCTIONS

Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

SECTION A

1a. Name of Establishment

Camp Saradac, Saratoga Summer Rec. Program

b. Address (No. & Street, City, State, Zip)

15 Vanderbilt Avenue, Saratoga Springs, NY 12866

2. Name of Operator City of Saratoga Springs Title Mayor

SECTION B

Check the appropriate category.

[ ] MIGRANT LABOR CAMP

Occupancy - check the correct number to determine fee.

[ ] 5 - 50 = $50.00

[ ] 51 or more = $100.00

[x] CHILDREN'S CAMPS = $200.00

TOTAL FEE DUE: $_____

SECTION C - Exemption Request

1. Is this facility used for religious, educational or philanthropic purposes? [ ] Yes [x] No

2. Is this facility operated by a municipality (city, town, village)? [x] Yes [ ] No

3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

[ ] Incorporation Papers [ ] Other (specify)_____

SECTION D - Certification

False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date 04/21/15

ATTENTION

This office cannot issue a permit without proof of Workers' Compensation & Disability Insurance coverage

The following current/valid forms must be submitted with your application:

1. **Workers' Compensation** (submit one from this list):
   - Form **C-105.2** (issued by your insurance carrier)
   - Form **U-26.3** (issued by the State Insurance Fund)
   - Form **SI-12**
   - Form **GSI-105.2**

AND

2. **Disability Insurance Benefits** (submit one from this list):
   - Form **DB-120.1** (issued by your insurance carrier)
   - Form **DB-155**

Contact your insurance carrier for these forms. Unfortunately, we are unable to substitute insurance forms submitted with recent permit renewal/applications for this requirement. Legal entity named on insurance forms must match name listed on permit.

OR

3. If you feel you are exempt from Workers Compensation/Disability coverage, you should submit a **CE-200 Exemption Certificate.**
   - The requirements and form can be found on-line at **http://www.wcb.ny.gov**.
   - The form and instructions are under the "*Employer/Businesses*" section. Select "*WC/DB Exemptions*" at the bottom of page, and then select "*Request for WC/DB Exemption (Form CE-200)*".
   - Complete, print and **sign** the form. Submit your **original** CE-200 with your application. We cannot accept copies of the CE-200.
   - A new CE-200 will be required for each event you intend on participating in.

Questions pertaining to Workers' Compensation / Disability Insurance requirements can be directed to the Workers' Compensation Board Office at (518) 473-9166 or toll free at 1-866-750-5157. Please contact this office at (518) 793-3893 with any other questions. Thank you for your cooperation.

New York State Children's Camps Fact Sheet
Acceptable Annual Water Supply Start-up Procedures
(Required by Section 7-2.6(d) of Subpart 7-2 of the NYS Sanitary Code)

January 4, 2005

An operator of a children's camp with an on-site potable water system that is not subject to continuous water use must ensure that an acceptable annual start-up procedure is completed. An operator of a camp with a potable water distribution system that is not subject to continuous water use, which receives water from an off-site public water system, may be required to implement a start-up procedure when the Permit-Issuing Official determines it to be necessary to ensure the satisfactory quality of the potable water.

The camp operator is required to use the start-up procedure contained in section 7-2.6(d)(1)(i) or an alternate procedure approved by the Commissioner of Health as stated in section 7-2.6(d)(1)(ii). Start-up procedures including required sampling must be completed at least 15 days prior to opening for the season.

Approved alternative procedures for start-up disinfection are described below. Only the start-up procedure(s) that are specified for the camp's potable water system type may be used. Facility operators that annually disinfect on-site well(s) as part of their routine start-up procedures should use procedure "C. Well Disinfection."

A. Water System Type: On-site Water System Using Chlorine Disinfection.

1. Flush the well (when applicable) and chlorine contact tanks by running water from a tap nearest the water supply source until the water appears to be free of particulates and discoloration.

2. Install the chlorination equipment and ensure that it is operational.

3. Flush all water lines thoroughly utilizing continuous chlorination until a free chlorine residual of at least 2.0 ppm is measured at all taps in the distribution system. Shut off all taps and allow the water to remain undisturbed in the water lines for 24 hours. Evaluate the system for leaks and pressure loss.

4. If the pressure (20 psi minimum) and chlorine residual (minimum 0.2 ppm) are acceptable, flush the distribution system again until the water appears to be free of particulates and discoloration. Confirm that a free chlorine residual of at least 0.2 ppm is present and then shut off all taps and allow the water to remain undisturbed for another 24 hours.

   *If the system was unable to maintain adequate pressure or a free chlorine residual, correct the problem and repeat steps 2 and 3 before continuing.

5. After 24 hours (total 48 hours), flush each tap and confirm that a free chlorine residual of at least 0.2 ppm but less than 4.0 ppm is present. Collect at least one water sample for Total Coliform analysis from a representative point in the distribution system for each water source. Submit the sample(s) to a laboratory certified by the New York State Department of

Health. Water sample analysis reports must be submitted to the permit-issuing official prior to permit issuance.

B. Water System Type: On-site Water System Using Ultra-violet (UV) Disinfection.

1. Flush the well by running water from a tap nearest the well until the water appears free of particulates and discoloration.

2. Install the ultra-violet disinfection equipment and ensure that it is operational.

3. Flush all water lines on the system with UV treated water until the water appears to be free of particulates and discoloration, and the distribution system is completely filled with treated water. Shut off all taps and allow the water to remain undisturbed in the water lines for 24 hours. Evaluate the system for leaks and pressure loss.

4. If the pressure (20 psi minimum) is acceptable, flush the distribution system again until the water appears to be free of particulates and discoloration.

   *If a problem was discovered regarding maintaining adequate pressure, correct the problem and repeat steps 2 and 3 before continuing.

5. Collect at least one water sample for Total Coliform analysis from a representative point in the distribution system and submit the sample to a laboratory certified by the New York State Department of Health. Water sample analysis reports must be submitted to the permit-issuing official prior to permit issuance.

C. Well Disinfection: On-site Well Water System Using Chlorine or Ultra-violet (UV) Disinfection

1. Run water until clear, using an outdoor faucet closest to the well or pressure tank.

2. Flush all water lines on the system with water until the water appears to be free of particulates and discoloration, and the distribution system is completely filled.

3. Mix one quart of unscented household bleach containing about 5% chlorine in 5 gallons of water in a large bucket or pail in the area of the well casing.

4. Turn electrical power off to the well pump. Carefully remove the well cap and well seal if necessary. Set aside.

5. Place the hose connected to outdoor faucet inside well casing. Turn electrical power back on to the well pump and turn water on to run the pump.

6. Carefully pour the water and bleach mixture from the bucket or pail down the open well casing. At the same time, continue to run the water from the hose placed inside the well casing. Mix a second solution of one quart of 5% household bleach to 5 gallons of water in a large bucket or pail and repeat this step.

7. At each indoor and outdoor faucet, run the water until a chlorine odor is present, then shut each faucet off.

8. Continue running water through the hose inside the well casing to recirculate the chlorine-treated water. Use the hose to wash down the inside of the well casing.

9. After one hour of recirculating the water, shut all faucets off to stop the pump. Disconnect power supply to pump. Remove recirculator hose from well.

10. Mix one quart of 5% household bleach in 5 gallons of water and pour mixture down the well casing. Repeat this process with a second mixture. Disinfect the well cap and seal by rinsing with a chlorine solution. Replace well seal and cap. Allow the well to stand idle for at least eight hours and preferably 12 to 24 hours. Avoid using the water during this time. Evaluate the system for leaks and pressure loss.

11. If the pressure (20 psi minimum) and chlorine residual (minimum 2.0 ppm) are acceptable, flush the distribution system again until the water appears to be free of particulates and discoloration then run the water using an outdoor faucet and garden hose in an area away from grass, shrubbery and waterways until the odor of chlorine disappears.

    *If the system was unable to maintain adequate pressure or a free chlorine residual, correct the problem and repeat step 10 before continuing.

12. When the system has been flushed (0.2 ppm to 4.0 ppm for chlorine disinfected systems or 0.0 ppm for U.V. disinfected systems), install the chlorination or ultra-violet disinfection equipment and ensure that it is operational.

13. Collect at least one water sample for Total Coliform analysis from a representative point in the distribution system for each water source. Submit the sample(s) to a laboratory certified by the New York State Department of Health. Water sample analysis reports must be submitted to the permit-issuing official prior to permit issuance.

D. Water Source: Off-site Public Water System.

1. Flush the seasonal use distribution lines with water from the approved off-site system until a detectable free chlorine residual* is present and the water appears to be free of particulates and discoloration. Shut off the taps and allow the water to remain in the lines undisturbed for 24 hours.

2. After 24 hours, flush each tap until the water appears to be free of particulates and discoloration and confirm that a detectable free chlorine residual* is present. Shut off the taps and allow the water to remain in the lines undisturbed for another 24 hours.

3. After 24 hours (48 hours total), flush each tap and confirm that a detectable free chlorine residual* is present. Collect at least one Total Coliform water sample from a representative point in the distribution system and submit it to a laboratory certified by the New York State Department of Health. Water sample analysis reports must be submitted to the permit-issuing official prior to permit issuance.

    *If no residual appears after continued flushing, please notify the operator of the public water supply and the local health department.

NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

CERTIFICATION OF SELF-INSPECTION OF A CHILDREN'S CAMPS

AS SPECIFIED BY SECTION 10NYCRR 7-2.4(d)(2)(ii)

I, _____(Name), certify under penalty of perjury that I have inspected my camp on_____(Date) and that the camp conforms or will be in conformance with Subpart 7-2 of the New York 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.

_____(___/___/___
)

(Signature) (Date)

Confidential: Completed by Camp Director

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: Camp Saradac Saratoga Summer Rec. Prog.

Facility Code: 45-B146 Date Open: 06/29/15 Date Close: 08/15/15 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	*Saratoga County Fair
☒ 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	☒	☐	34	5	10	20	15	50	50	10	10				
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: Matthew C. Lacy

Date of Birth: 10/28/89

Education: Bachelor of Professional Studies in Management; Specializing in Sports Management

Qualifying Experience: 3 years Assistant Director; Camp Saradac - Summer 2007-present

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): Mary Eagan

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: 437387-1

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	American Heart Association	BLS/Health Care Provider	06 / / 14
First Aid	☒ Health Director	☐ Assistant	American Heart Assoication	Heart Saver First Aid	06 / / 14

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: Joanne D. Yepsen Title: Mayor Date: 04 / 21 / 15

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

This will be submitted after Camp Saradac Staff is hired.

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: Camp Saradac Saratoga Summer Rec. Prog. Facility Code: 45-B145

Date Open: 06/29/15 Date Close: 08/15/15

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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This will be submitted when Camp Saradac Staff is hired.

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.

	Counselors	
Staff Ages	**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: Joanne D. Yepsen Title: Mayor Date: ___/___/___

AQUATIC CERTIFICATIONS
for NYS Bathing Facilities

Fact Sheet – February 2015
(Go to www.health.ny.gov to view most current certification list)

Standards for aquatic/lifeguard certifications are contained in New York State Sanitary Codes (SSC) Subpart 6-1, Section 6-1.31, Swimming Pools; Subpart 6-2, Section 6-2.20, Bathing Beaches; and Subpart 7-2, Section 7-2.5(g), Children's Camps. When the SSC requires "lifeguard supervision" or a "qualified lifeguard" at a bathing facility, an approved lifeguard certification SPECIFIC to the type of bathing facility is required.

NOTE:

- **All lifeguards must possess separate cardiopulmonary resuscitation (CPR) certification in an approved course listed on the NYS CPR fact sheet unless otherwise indicated in the below table. All CPR certificates are valid for 1 year from course completion, regardless of the expiration date noted on the card.**
- Lifeguard certifications shall be valid for the time period specified by the certifying agency, but may not exceed a consecutive three-year period from course completion. Multiyear lifeguard certifications that include CPR require a CPR certification each year.
- Children's camp lifeguards must be at least 17 years of age, except;
  - A maximum of 50% of the required lifeguards on duty may be 16 years of age;
  - Lifeguards for wilderness swimming must be at least 18 years of age.
- Supervising lifeguards must possess at least Supervision Level IIb certification, be at least 18 years old, and have at least 2 seasons of lifeguarding experience.

ACCEPTED COURSES		SUPERVISION LEVEL *Marked boxes indicate acceptability*		
PROVIDER	**CERTIFICATION TITLE**	**Level I Surf**	**Level II b Pool & Beach**	**Level II a Pool Only**
American Red Cross (ARC) A CERTIFICATION IN THE OLD ARC CURRICULUM REMAINS VALID UNTIL EXPIRATION, BUT NO LATER THAN 8/30/2015, AS COURSES IN THE OLD ARC CURRICULUM WILL NO LONGER BE TAUGHT AFTER 8/31/2012. FOR COURSES INDICATED AS NEW FORMAT, THE FOLLOWING APPLY: 1) LIFEGUARDING AND FIRST AID CERTIFICATIONS ARE VALID FOR 2 YEARS FROM DATE OF ISSUANCE. 2) A SEPARATE CERTIFICATE FOR CPR IS NOT REQUIRED IN FIRST YEAR OF CERTIFICATION. *THE WATERFRONT SKILLS MAY BE A SEPARATE CERTIFICATE.	Lifeguarding/First Aid/CPR/AED (New Format)			X
	Lifeguarding/First Aid/CPR/AED with Waterpark Skills Certificate (New Format)			X
	Lifeguarding/First Aid/CPR/AED with Waterfront Skills Certificate (New Format)*		X	X
	Lifeguarding			X
	Waterpark Lifeguarding			X
	Waterfront Lifeguarding		X	X
American Lifeguard Association (ALA) CERTIFICATE MUST STATE THE WORDS "INSTRUCTOR-LED COURSE"	Lifeguarding Instructor-Led Course			X
	Waterpark Lifeguarding Instructor-Led Course			X
	Waterfront Lifeguarding Instructor-Led Course		X	X
Boy Scouts of America (BSA) ALL CERTIFICATIONS ARE VALID FOR 3 YEARS FROM DATE OF ISSUANCE AND CARD HOLDER MUST BE AT LEAST 15 YEARS OF AGE (17 YEARS OF AGE FOR CHILDREN'S CAMPS).	Lifeguard, BSA		X	X
	Aquatics Instructor, BSA		X	X
Breezy Point Cooperative, Inc.	Breezy Point Surf Lifeguard	X		
Cattaraugus County EMS	Cattaraugus County EMS Lifeguard Training Program		X	X
Hamptons Consortium	Hamptons Consortium Surf Lifeguard	X	X	X
Ellis & Associates Inc. International Lifeguard Training Program Separate certificate for CPR is NOT required. *CERTIFICATE MUST INDICATE COMPLETION OF OPEN WATER TRAINING.	Pool Lifeguard Training			X
	Special Facilities Lifeguard Training			X
	Special Facilities Lifeguard Training with Open Water Training*		X	X
Incorporated Village of Saltaire	Ocean Lifeguard Certificate	X		
	Bay Front Lifeguard Certificate		X	

ACCEPTED COURSES		SUPERVISION LEVEL *Marked boxes indicate acceptability*		
PROVIDER	**CERTIFICATION TITLE**	**Level I Surf**	**Level II b Pool & Beach**	**Level II a Pool Only**
Nassau County Department of Parks, Recreation and Museums	"Day Camp Only"			X
	Grade 1A			X
	Grade 1B			X
	Grade II		X	X
	Grade III	X	X	X
New York City Department of Parks	Municipal Lifeguard	X	X	X
	Municipal Lifeguard "pool only"			X
New York State Department of Environmental Conservation	New York State Lifeguard		X	X
Royal Life Saving Society, Canada ALL CERTIFICATIONS ARE VALID FOR 2 YEARS FROM DATE OF ISSUANCE.	National Lifeguard Service (NLS) Pool			X
	National Lifeguard Service (NLS) Waterfront		X	
	National Lifeguard Service (NLS) Surf	X		
	National Lifeguard Service (NLS) Waterpark			X
Starfish Aquatics Institute, Inc. CERTIFICATION IS VALID FOR 1 YEAR FROM DATE OF ISSUANCE AND CERTIFICATE MUST SPECIFY "MEETS NY STATE DEPARTMENT OF HEALTH REGULATIONS." SEPARATE CERTIFICATE FOR CPR IS NOT REQUIRED IN THE FIRST YEAR OF CERTIFICATION. *IN "SPECIALTY MODULE TRAINING" SECTION OF CERTIFICATION CARD, "WATERFRONT" MUST NOT BE CROSSED OUT.	StarGuard Best Practices for Lifeguards			X
	StarGuard Best Practices for Lifeguards with Waterfront Specialty Module Training*		X	X
Suffolk County Department of Parks	Ocean Lifeguard Training	X		
	Stillwater Lifeguard Training Course		X	
Town of Babylon	Ocean Lifeguard	X	X	X
	Stillwater Lifeguard Training Course		X	X
Town of Brookhaven	Ocean Theory Course	X	X	X
Town of East Hampton	Surf Lifeguard	X	X	X
	Pool and Beach Lifeguard		X	X
Town of Islip	Surf Lifeguard	X	X	X
	Pool and Beach Lifeguard		X	X
Town of Southampton	Ocean Lifeguard	X	X	X
	Stillwater Lifeguard		X	X
Village of Ocean Beach	Ocean Beach Atlantic Ocean Lifeguard Course	X	X	X
YMCA	YMCA Lifeguard		X	X
	Lifeguard		X	X
	2011 Edition Lifeguard Certification		X	X

SHALLOW WATER CERTIFICATION

(Valid for shallow pools as indicated below)

PROVIDER	CERTIFICATION TITLE
American Red Cross (ARC) A CERTIFICATION IN THE OLD ARC CURRICULUM REMAINS VALID UNTIL EXPIRATION, BUT NO LATER THAN 8/30/2015, AS COURSES IN THE OLD ARC CURRICULUM WILL NO LONGER BE TAUGHT AFTER 8/31/2012. FOR COURSES INDICATED AS NEW FORMAT, THE FOLLOWING APPLY: 1) CERTIFICATIONS ARE VALID FOR 2 YEARS FROM DATE OF ISSUANCE. 2) A SEPARATE CERTIFICATE FOR CPR IS NOT REQUIRED IN FIRST YEAR OF CERTIFICATION.	Shallow Water Lifeguarding/First Aid/CPR/AED (New Format) (Valid for water depths of 5 feet or less.)
	Shallow Water Attendant (Valid for water depths of 4 feet or less.)
	Aquatic Attraction Lifeguarding (New Format) (Valid for water depths of 3 feet or less).
American Lifeguard Association (ALA) CERTIFICATE MUST STATE THE WORDS "INSTRUCTOR-LED COURSE"	Shallow Water Lifeguard Instructor-Led Course (Valid for water depths of 4 feet or less.)
Ellis & Associates Inc. **International Lifeguard Training Program** SEPARATE CERTIFICATE FOR CPR IS NOT REQUIRED IN THE FIRST YEAR OF CERTIFICATION.	Shallow Water Lifeguard (Valid for water depths of 5 feet or less.)

PROGRESSIVE SWIMMING INSTRUCTOR*
for NYS Children's Camps

Fact Sheet – February 2015
(Go to www.health.ny.gov. to view most current certification list)

A progressive swimming instructor is required to assess the swimming ability of each camper prior to allowing the child to participate in aquatic activities.

The following courses meet the certification requirements as specified in Section 7-2.5(f) of Subpart 7-2 of the New York State Sanitary Code:

Accepted Courses	
Provider	**Certification Title**
American Red Cross (ARC)	➢ Water Safety Instructor
Boy Scouts of America	➢ Aquatics Instructor, BSA ➢ Cub Scout Aquatics Supervisor, BSA
Canadian Red Cross	➢ Water Safety Instructor
Orchard Park Recreation	➢ Western New York Swimming Instructor ➢ Western New York Swimming Instructor Trainer
YMCA	➢ Special Population Swimming Instructor ➢ YMCA Swim Lessons Instructor
Starfish Aquatics Institute	➢ Starfish Swimming Instructor – certifications must indicate specialty program training in both Stroke and Swim School
PADI	➢ PADI Swimming Instructor – certifications must indicate specialty program training in both Stroke and Swim School

*A progressive swimming instructor may not perform lifeguard duties unless currently certified as a qualified lifeguard (see "Aquatic Certifications" fact sheet) and the individual is not concurrently performing instructional duties.

Camp Trip Swimming Program Safety Certifications
for NYS Children's Camp

Fact Sheet – February 2015
(Go to www.health.ny.gov to view the most current certification list)

When swimming is conducted during a camp trip to an aquatics facility that is supervised by qualified lifeguard(s), the camp must supply one additional lifeguard or a staff member possessing training in Children's Camp Swimming Program Safety for each 75 campers at the swimming activity (See Aquatic Certification Fact Sheet for a list of qualified lifeguard certification). A camp supplied lifeguard or staff trained in swimming safety is not required for aquatic amusement park activities that allow only one or two patrons in the water at a time and the activity water depth does not exceed chest deep for non-swimmers.

The following courses have been accepted by the Department as meeting or exceeding course standards for training in Children's Camp Swimming Program Safety specified in Section 7-2.11(a)(4)(iv)(a) of the State Sanitary Code:

Provider	Certification Title*
American Red Cross (ARC) Lifeguard Management (LGM) certifications obtained online: – As of 1/1/14, LGM is only offered online. In-person testing is obtained through ARC Lifeguarding Instructors that are ARC Authorized Providers. – Certification expiration date is based on the LGM certificate, not the in-person testing certificate date.	➢ Lifeguard Management – certifications issued after 12/31/13 must be accompanied by a separate certification indicating in-person testing session. ➢ Lifeguard Instructor
American Red Cross on Long Island	➢ Pool Activity Leader
Boy Scouts of America	➢ Aquatics Supervision
YMCA	➢ Aquatics Management ➢ Aquatics Management Trainer

* Certifications are valid for the time period specified by the certifying agency, but may not exceed a consecutive three-year period from course completion.

CAMP AQUATICS DIRECTOR

for NYS Children's Camp Bathing Facilities

Fact Sheet – February 2015

(Go to www.health.ny.gov to view most current certification list)

A camp aquatics director must oversee all swimming activities that occur at swimming pools and bathing beaches operated as part of a children's camp. This person shall supervise lifeguards and other required staff during swimming activities and implement the camp safety plan. The camp aquatics director must:

- be at least 21 years of age
- have a minimum of:
  - one season of previous experience as a camp aquatics director at a New York State children's camp; or
  - two seasons of previous experience consisting of at least 12 weeks as a children's camp lifeguard which had more than one lifeguard supervising it at a time; or
  - 18 weeks of previous experience as a lifeguard at a swimming pool or bathing beach, which had more than one lifeguard supervising it at a time.
- hold an accepted and current cardiopulmonary resuscitation (CPR) certificate as listed on the Fact Sheet entitled "Cardiopulmonary Resuscitation (CPR) Certification for NYS Children's Camps and NYS Bathing Facilities"
- annually review and document the review of the camp's safety plan for swimming
- possess current certification in a training course for lifeguard supervision and management as described below:

Acceptable Lifeguard Supervision and Management Courses

(Certifications are valid for the time period specified by the provider, but may not exceed three years from the date of course completion.)

Provider	Certification Title
American Red Cross (ARC) Lifeguard Management (LGM) certifications obtained online: – As of 1/1/14, LGM is only offered online. In-person testing is obtained through ARC Lifeguarding Instructors that are ARC Authorized Providers. – Certification expiration date is based on the LGM certificate, not the in-person testing certificate date.	➢ Lifeguard Management – certifications issued after 12/31/13 must be accompanied by a separate certification indicating in-person testing session. ➢ Lifeguarding Instructor
Boy Scouts of America	➢ BSA Aquatic Instructor
New York State Department of Environmental Conservation	➢ New York State Lifeguard Management
YMCA	➢ Aquatics Management ➢ Aquatics Management Trainer

An Aquatics Director may not perform lifeguard duties unless currently certified as a qualified lifeguard, or assess swimming ability unless currently certified as a progressive swimming instructor (see corresponding Fact Sheets available at www.health.ny.gov or from your local health department).

Learn-to-Swim Programs
for NYS Children's Camps

Fact Sheet – February 2015

(Go to www.health.ny.gov to view most current certification list)

Subpart 7-2 of the State Sanitary Code allows non-swimmers to enter water that is chest deep or greater when participating in a learn-to-swim program that has been determined to use a supervision protocol which protects campers from injury or drowning. The following programs have been determined to be acceptable:

Acceptable Programs*
American Red Cross
Boy Scouts of America
Orchard Park Recreation
PADI
Starfish Aquatics
YMCA

- Instructors must possess current certification as a progressive swimming instructor (PSI) in the program being utilized to teach swimming.

- Qualified lifeguards must supervise learn-to-swim programs. A PSI may not perform lifeguard duties unless currently certified as a qualified lifeguard (see "Aquatic Certification" fact sheet) and he/she is not concurrently performing teaching duties.

- A Buddy System and Board System (or equivalent) of supervising and checking bathers must be implemented during all swimming activities including learn-to-swim programs.

*Children's camps may utilize learn-to-swim programs that are not listed above to teach swimming at camp; however, non-swimmers must be restricted to water that is less than chest deep at all times.

CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATION

for NYS Children's Camps and NYS Bathing Facilities

Fact Sheet – February 2015

(Go to www.health.ny.gov to view the most current certification list)

The New York State Sanitary Code (SSC) requires certain staff to possess a valid two-rescuer CPR certification in a course accepted by the Department as providing an adequate level of training as follows:

Children's Camps (Subpart 7-2 of the SSC) - CPR certification is required for the health director and other staff specified in sections 7-2.8 and 7-2.11(a)(5), aquatics director, lifeguards, and certain trip and activity leaders[1].

Swimming Pools and Bathing Beaches (Part 6 of the SSC) - CPR certification is required for all lifeguards (Supervision Levels I, IIa, IIb).

CPR CERTIFICATIONS ARE VALID FOR 1 YEAR FROM THE DATE OF CERTIFICATION, REGARDLESS OF EXPIRATION DATE ON CARD

Accepted Courses	
Provider	**Certification Title**
American Red Cross	• CPR/AED for the Professional Rescuer and Healthcare Providers • Lifeguarding/First Aid/CPR/AED
American Heart Association Certification listing "Laerdal Medical" as the "TC address contact Info" and "Course Location" on the back of the card are **not acceptable**.	• BLS Instructor • BLS for Health Care Providers
American Lifeguard Association	• Professional Rescuer CPR **Instructor-led Course**
American Safety & Health Institute	• American Safety and Health CPR for Professional Rescuers (CPR PRO)
Emergency Care and Safety Institute	• Health Care Provider CPR
EMS Safety Services, Inc.	• CPR/AED for the Professional Rescuer
Heart & Stroke Foundation of Canada	• Level C - Basic Rescuer CPR
National Safety Council	• NSC Basic Life Support for Healthcare Providers (Course title - Basic Life Support for Healthcare and Professional Rescuers)
New York City Department of Parks & Recreation	• Municipal CPR: Basic Life Support
New York State Department of Environmental Conservation	• CPR/AED for Lifeguards, Camp Counselors and Camp Directors
Regional Emergency Medical Services Council of New York City	• BCLS for Health Care Providers Course
St. John Ambulance Canada	• Level C (Basic Rescuer) CPR

[1] A trip leader of a camp trip that includes an activity where emergency medical care is not readily available or an activity such as wilderness hiking, rock climbing, camping, horseback riding, bicycling, swimming and/or boating shall possess or be accompanied by staff who possess certification in a course listed on this Fact Sheet.

An activity leader of an activity on the camp property where other CPR certified staff is not readily available shall possess or be accompanied by staff who possess certification in a course listed on this Fact Sheet.

FIRST AID CERTIFICATIONS

for NYS Children's Camp Staff

Fact Sheet – February 2015

(Go to www.health.ny.gov to view most current certification list)

Subpart 7-2 of the State Sanitary Code requires the health director, other staff specified in section 7-2.8, and certain camp trip and activity leaders[1] to possess valid certification in first aid. The courses listed below have been accepted by the Department as being equivalent to or exceeding first aid course standards specified in Section 7-2.2(m). Some medical personnel may possess training and experience that is equivalent to or exceeds this certification requirement. A résumé or list of qualifications should be submitted to the local permit-issuing official for evaluation.

Acceptable certifications for camp CPR staff are listed on the Fact Sheet titled Cardiopulmonary Resuscitation (CPR) Certification for NYS Children's Camps and NYS Bathing Facilities.

Accepted Courses (First Aid certifications are valid for the time period specified by the provider, but may not exceed three years from the date of course completion.)	
Provider	**Certification Title**
American Red Cross	➢ Emergency Medical Response ➢ Responding to Emergencies (any certification title containing the wording "Responding to Emergencies" is acceptable) ➢ Wilderness and Remote First Aid
American Safety & Health Institute	➢ Advanced First Aid – Certification must be accompanied by a Recognition of Participation in the ASHI training program approved by the New York State Department of Health. ➢ Basic Wilderness First Aid ➢ Wilderness First Aid ➢ Wilderness First Responder ➢ Wilderness EMT
Canadian Red Cross Society	➢ Standard First Aid
Emergency Care and Safety Institute	➢ Advanced First Aid ➢ Emergency Medical Responder ➢ Wilderness First Aid BSA (16 hours) (course title – Boy Scouts of America Wilderness First Aid) ➢ Wilderness First Aid Basic ➢ Wilderness First Aid Standard ➢ Wilderness First Aid Advanced Level
National Safety Council	➢ NSC Emergency Medical Response ➢ NSC Advanced First Aid (Course title – NSC Advanced First Aid, CPR & AED)
National Ski Patrol	➢ Outdoor Emergency Care Technician
National Registry of Emergency Medical Technicians[2]	➢ Emergency Medical Responder ➢ Emergency Medical Technician ➢ Advanced Emergency Medical Technician ➢ Paramedic
New York State Department of Health	➢ Certified First Responder ➢ Emergency Medical Technician ➢ Advanced Emergency Medical Technician ➢ Critical Care ➢ Paramedic

New York State Department of Environmental Conservation	➢ Summer Camp First Aid for Camp Counselors and Camp Directors
SOLO Wilderness Emergency Medicine	➢ Wilderness First Aid ➢ Wilderness First Responder ➢ Wilderness EMT
St. John Ambulance Canada	➢ Advanced Medical First Responder - Level 1 ➢ Advanced Medical First Responder - Level 2 ➢ Standard First Aid
Wilderness Medical Associates	➢ Wilderness Advanced First Aid ➢ Wilderness First Responder ➢ Wilderness EMT ➢ Wilderness First Aid 16 Hours (Wilderness First Aid **option B** – 16 Hours is **not** acceptable)
Wilderness Medicine Institute of the National Outdoor Leadership School	➢ Wilderness Advanced First Aid ➢ Wilderness First Responder ➢ Wilderness EMT

[1]A trip leader of a camp trip that includes an activity where emergency medical care is not readily available or an activity such as wilderness hiking, rock climbing, camping, horseback riding, bicycling, swimming and/or boating shall possess or be accompanied by staff who possess certifications in one of the above acceptable courses; For camp trip swimming activities where emergency medical care is readily available, the certifications listed below may be substituted.

An activity leader of an activity on the camp property where other staff certified in first aid in accordance with Section 7-2.8 of Subpart is not readily available, shall possess or be accompanied by staff who possess certifications in one of the above acceptable courses.

[2]Most states utilize the National curriculum for their EMT certifications. Individuals that can provide proof that their state utilizes the National curriculum may be accepted. EMT certifications from states that do not utilize the National curriculum may be accepted on a case by case basis.

At a SUMMER DAY CAMP, when the camp's program does not include equestrian, bicycling, challenge course, rock climbing, boating, riflery, archery, motorized recreational vehicles, wilderness hiking/activities, and similar activities; and emergency medical care is available within 10 minutes, the following certifications may be substituted for the above courses.

These certifications do not satisfy the requirement for camp CPR certified staff. Acceptable certifications for CPR are listed on the Fact Sheet titled Cardiopulmonary Resuscitation (CPR) Certification for NYS Children's Camps and NYS Bathing Facilities.

Provider	Certification Title
American Lifeguard Association	➢ Community First Aid and Safety Instructor-Led Course* ➢ Lifeguard Training – Community First Aid and Safety Instructor-Led Course* *Certificates must include words Instructor-Led Course
American Heart Association	➢ Heartsaver First Aid ➢ Heartsaver First Aid, CPR, AED ➢ Heartsaver Pediatric First Aid ➢ Heartsaver Pediatric First Aid CPR AED
American Red Cross	➢ First Aid/CPR/AED ➢ Adult and Pediatric First Aid/CPR/AED
American Safety and Health Institute (ASHI)	➢ Basic First Aid* ➢ Pediatric CPR, AED, and First Aid* *Certification must be accompanied by a Recognition of Participation in the corresponding ASHI training program approved by the New York State Department of Health

EMS Safety Services Inc.	➢ Basic First Aid ➢ Basic First Aid & CPR
Emergency Care and Safety Institute	➢ First Aid for NY Day Camps, Basic Level
Medic First Aid	➢ PediatricPlus CPR, AED, and First Aid - Certification must be accompanied by a Recognition of Participation in Medic First Aid training program approved by the New York State Department of Health
National Safety Council	➢ NSC First Aid ➢ NSC First Aid, CPR & AED

EPINEPHRINE AUTO-INJECTOR PROGRAM CERTIFICATIONS
for NYS Children's Camps

Fact Sheet – February 2015
(Go to www.health.ny.gov to view most current certification list)

Section 3000-c of Public Health Law permits children's camps to establish an epinephrine auto-injector program to stock and allow specially trained camp staff to use an epinephrine auto-injector device to treat life-threatening allergic reactions (also known as anaphylaxis). Please refer to the Department of Health Fact Sheet entitled "Epinephrine Auto-Injector Use by Children's Camps" for more detailed information about establishing an epinephrine auto-injector program at a camp.

To participate in an auto-injector program, children's camp operators must develop, sign and implement a collaborative agreement with an emergency heath care provider (physician or hospital) who will oversee the camp's program. The camp's emergency health care provider should determine which of the following approved courses will be used to train camp staff.

Courses require annual recertification.

Provider	Certification Title
American Red Cross	➢ Epinephrine Auto-Injector Training ➢ Anaphylaxis and Epinephrine Auto Injector
New York State Department of Health Bureau of Emergency Medical Services*	➢ Training Program Outline for Unlicensed or Uncertified Personnel to Administer Epinephrine by Auto-Injector in Life-Threatening Situations
Lifesaving Enterprises	➢ Epinephrine Auto-Injector Training

*The Bureau of Emergency Medical Services (BEMS) does not provide training to camp staff; however, their approved training curriculum is available for use by the camp's emergency health care provider (EHCP) or individual designated by the EHCP to provide the training to camp staff. BEMS curriculum is available from the BEMS Operations Unit at (518) 402-0996 or at http://www.health.ny.gov/professionals/ems/pdf/epitraining.pdf. Additionally, BEMS Policy Statement on Epinephrine Auto-Injectors is available at http://www.health.ny.gov/nysdoh/ems/pdf/11-08.pdf.

NYS Sex Offender Registry Search Procedures for Children's Camps

Fact Sheet – March 2013

Section 7-2.5(l) of the New York State Sanitary Code and Article 13-B of the Public Health Law requires children's camp operators to determine whether an employee or volunteer at the camp is listed on the New York State Division of Criminal Justice Services (DCJS) Sex Offender Registry. Checks of the Registry must be completed prior to the day the employee or volunteer starts work at the camp and annually thereafter prior to their arrival at camp. The law applies to all children's camps (day, traveling day and overnight) and to all prospective employees and volunteers at the camp regardless of their job title/responsibilities or employment status (full or part-time).

How to conduct a search:

A search of the Sex Offender Registry is a free and simple service provided by DCJS. Search requests may be submitted by email, CD, fax, regular mail, and telephone depending upon the number of individuals requested to be checked against the Registry. Procedures for submitting search requests are available from DCJS at http://www.criminaljustice.ny.gov/nsor/800info_cdsubmit.htm.

Please note that at this time, the feature on the DCJS website for conducting a web based search of the Registry does **not** satisfy the requirement for camps because the web based search only identifies Risk Level 2 and 3 offenders.

DCJS response:

The DCJS prefers responding to requests to search the Registry by fax; however, they will respond by regular mail if a fax number is not available/provided. DCJS's response will indicate the total number of individuals checked against the Registry and either the names of the individuals listed on the Registry and their risk level, or that no matches were found. The list of employees/volunteers submitted to be searched will not be returned by DCJS unless specifically requested by the camp operator with the initial search request submittal. Results of search requests made by telephone will be provided during the phone call.

Risk Levels:

Sex offenders are classified according to their risk of re-offending. The court may assign one of the following three risk levels:

- Level 1 – low risk of repeat offense;
- Level 2 – moderate risk of repeat offense; or
- Level 3 – high risk of repeat offense.

Note – While waiting a risk level assignment from the court, an individual is categorized as "Pending."

Documentation:

A copy of prospective employee's or volunteer's information submitted to DCJS and letter from DCJS indicating the search results must be kept on file at camp and available for review during Health Department inspections. Camps that use the telephone screening process must document the screening date, DCJS response and DCJS screener ID number.

Additional information

For more information regarding the Division of Criminal Justice Services Sex Offender Registry, call (518) 457-3167 or visit their website http://www.criminaljustice.ny.gov.

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.ny.gov/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.

Confidential: Completed by the Camp Director

LDSS-3370 (Rev. 09/2014) 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):
SHD	7154		M	(518) 793 - 3893

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

AGENCY NAME: NEW YORK STATE DEPT OF HEALTH

AGENCY LIAISON: GLENS FALLS DISTRICT OFFICE

STREET ADDRESS 77 MOHICAN ST

CITY: GLENS FALLS **STATE:** NY **ZIP CODE:** 12801

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 number with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES - Record the appropriate category.

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

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 424a requires the collection of a $25.00 fee 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 twenty-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 424a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, 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.ny.gov/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 to order forms at 518-473-0971.

LDSS-3370 (Rev. 09/2014)

Confidential: Completed by the Camp Director

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

Confidential: Completed by Camp Director

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: ______________________________

Other Household Members are (please print clearly):

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y

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

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

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

Allegation of Abuse Report Form

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

A. FACILITY INFORMATION

Facility Name:_____ Facility Code:_____

Facility Type: Θ Day Θ Overnight Θ Municipal Day Camp Are 20% or more of the campers developmentally disabled? Θ Yes Θ No Date Reported ____/___/____

B. EVENT INFORMATION

eHIPS Incident Number:-_____ (Note: eHIPS will assign when entered into system)

Note: If reportable injuries occurred as a result of this incident, complete an injury report form as well

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

Where did injury occur? _____ Specify for 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	

Nature of Allegation: ___Physical Abuse ___ Sexual Abuse ___ Both Physical and Sexual Abuse

Note: For multiple victim abuse incidents, attach additional sheets containing victim information.

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 information must be collected and maintained by LHD for appropriate investigation and follow-up.

Age: _____ **Sex:** Θ Female Θ Male

Status: Θ Camper Θ Developmentally Disabled Camper Θ CIT/Jr. Counselor Θ Counselor Θ Other Staff* Θ Other* Specify _____

What was the victim doing? _____

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

* Specify_____

2. Victim Information- (Complete for multiple victims)

Number of campers: male____ female____ **Number of staff:** male _____ female____ **Number of others:** male _____ female_____

D. SUPERVISION

1. Supervision during incident (indicate as many as apply) _____ _____ _____ _____

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 *
* Specify_____

E. ALLEGED PERPETRATOR INFORMATION: Attach additional sheets if multiple perpetrators.

Name: _____	Age:_____	Sex_____	**Information in shaded area is confidential**

Status: Θ CIT/Jr. Counselor Θ Counselor Θ No relation to camp Θ Trespasser Θ Visitor
Θ Camper Θ Dev. Disabled Camper Θ Other Staff* Θ Unknown *Specify_____

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- Do not include the full names of people involved with the incident. Use the first and last name initials or other similar code.

Allegation of Abuse- Provide a description of the event, conclusions and DOH recommendations: Include statements pertaining to Subpart 7-2 compliance and the acceptability/implementation of the camp written plan. Recommendations should include whether or not administrative action against the camp will be taken as well as the steps that must be taken to prevent similar incidents in the future. See Environmental Health Procedure CSFP-142 for guidance in addition to completing this electronic report.

Information received by: _____ Title:_____

Report reviewed by: _____ Title:_____

N:\CAMPS\DOH61\abuse.doc

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

Fire Report Form

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

A. FACILITY INFORMATION

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

Facility Type: Θ Day Θ Overnight Θ Municipal Day Camp Are 20% or more of the campers developmentally disabled? Θ Yes Θ No Date Reported ____/___/____ to Local Health Department

B. EVENT INFORMATION

eHIPS Incident Number: _____ **(Note: eHIPS will assign when entered into system)**

Note: If a reportable injury occurred as a result of the fire, complete an Injury Report Form in addition to this form. Did an injury occur? Θ Yes Θ No

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

Where did the fire occur? _____ Specify for locations marked with an asterisk: _____

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

C. 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: ____/____/____

D. NARRATIVE- 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 incident. Include details of the suspected cause of the fire, fire detection and fire department notification, personnel evacuation, assembly and accountability, as well as the camp's compliance with Subpart 7-2 and the written plan.

_____

_____

_____

_____

Information received by: _____ Title:_____

Report reviewed by: _____ Title:_____

NEW YORK STATE DEPARMTENT OF HEALTH
Bureau of Community Sanitation and Food Protection
Children's Camp Program

Epinephrine Administration Report

Instructions: See Instructions on back of form prior to completing

FACILITY INFORMATION

eHIPS Incident Number: _____

Camp Name:_____ Facility Code:_____

Camp Type: o Day o Overnight Camp for developmentally disabled? o Yes o No Date Reported_____/_____/_____ to Local Health Department

Incident Date: _____/_____/_____ Incident Time: _____:_____ (Military time)

Location of Incident: o Camp o Camp Trip Specify:_____

Does the camp participate in the Epinephrine administration program? o Yes o No

Was the camp emergency care provider notified of the incident? o Yes o No

VICTIM INFORMATION

eHIPS Victim Number: _____

Name of Patient: (Last, First, M.I.) _____

Home Address Street _____

Town, Village or City _____ State_____

Name of Parent or Guardian (Last, First, M.I.)_____

Home Phone Number (_____) _____ **Material in shaded area is confidential**

Age: _____ Weight:_____ Sex: o Female o Male

Status: Θ Camper Θ Developmentally Disabled Camper Θ CIT/Jr. Counselor Θ Counselor Θ Other Staff*
Θ Other* (Specify)_____

EVENT INFORMATION

Type of Incident Resulting in Need to Administer Epinephrine:

o Bee Sting o Other Insect Bite o Asthma Attack o Food Allergy* o Other*

* Specify:_____

Time Epinephrine administered: ____:_____ (Military time) Number of auto-injector administrations:_____

Type of Epinephrine Injector: o Epi-pen® o Epi-pen Jr.® o Other Specify:_____

Where on body was epinephrine injected?_____

Indicate source of Epinephrine: o Camp supply o Patient prescription o Other Specify:_____

Epinephrine Administered by: Name:_____ Indicate applicable certification(s) below

o Doctor o Nurse Practitioner o Physician's Assistant o RN o LPN o EMT o First Aid Certified Staff

o Self-Administered o Other _____

Epinephrine training course: o NYS EMS o Red Cross o None o Other _____

Name of EMS agency providing care:_____ Phone:_____

Name and location of health care facility patient was transported to:_____

Was patient admitted? o Yes o No

Narrative: Provide a written description of the event on back of form.

Instructions for completing the Children's Camp Epinephrine Administration Report

Local health department staff are responsible for completion of the form and submittal to the Bureau of Community Sanitation and Food Protection. Complete the Epinephrine Administration Report form for Epinephrine Use by Children's Camp Staff or campers and forward a copy of the form to the BCSFP within 48 hours of notification from the camp.

Children's camps must report epinephrine administration to the local health department whether or not they are participating in the auto injector program and regardless if medication was from the camp's stocked supply or brought to camp by a camper or staff.

Description of Incident:

Describe symptoms and circumstances surrounding the administration of the Epinephrine including the cause of anaphylaxis, signs and symptoms displayed by the patient prior to administration and the patient's response to the administered drug. Enter the events in the chronological order of their occurrence. Include available information about the event's outcome such as whether the patient was discharged from the hospital, returned to camp or went home. Use additional sheets if needed.

Report completed by:_____ Title:_____ Date: _____/_____/_____

Local Health Department:_____ Phone: (_____)_____

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

Potential Rabies Exposure Report

See Environmental Health Manual Procedure CSFP-146 and back of form before completing.

Camp Name:_____ **Address:**_____

Exposure Date: ___/___/___ **Time:** ___:___ (Military time) **Report Date:** ___/___/___ **eHIPS Log Number:** _____

Rabies Analysis- Provide the following information for each animal involved in the incident.

Animal Description	Submitted for Rabies Analysis		If Submitted for Analysis, Indicate Results		
#1	o Yes	o No	o Positive	o Negative	o Untestable
#2	o Yes	o No	o Positive	o Negative	o Untestable
#3	o Yes	o No	o Positive	o Negative	o Untestable
#4	o Yes	o No	o Positive	o Negative	o Untestable

If exposure was a result of a bat entering a building, were bat exclusion techniques utilized after the incident to prevent future bat entry and potential human exposure? o Yes o No

COMPLETE FOR **ALL** PERSON(S) INVOLVED IN THE EXPOSURE INCIDENT – Shaded information is confidential

1. Victim Information: eHIPS Victim Number: _____ **Exposure Date** ___/___/___ **Time** ____:____ **(military)**

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** o Male o Female **Status:** o Camper o Developmentally Disabled Camper o CIT/Jr. Counselor o Counselor o Other Staff* o Other* (Specify*)_____

Animal	Type of Exposure (select from back of form)	Animal	Type of Exposures (select from back of form)
#1		#3	
#2		#4	

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? o Yes o No o Refused

2. Victim Information: eHIPS Victim Number: _____ **Exposure Date** ___/___/___ **Time** ____:____ **(military)**

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** o Male o Female **Status:** o Camper o Developmentally Disabled Camper o CIT/Jr. Counselor o Counselor o Other Staff* o Other* (Specify*)_____

Animal	Type of Exposure (select from back of form)	Animal	Type of Exposures (select from back of form)
#1		#3	
#2		#4	

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? o Yes o No o Refused

3. Victim Information: eHIPS Victim Number: _____ **Exposure Date** ___/___/___ **Time** ____:____ **(military)**

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** o Male o Female **Status:** o Camper o Developmentally Disabled Camper o CIT/Jr. Counselor oCounselor o Other Staff* o Other* (Specify*)_____

Animal	Type of Exposure (select from back of form)	Animal	Type of Exposures (select from back of form)
#1		#3	
#2		#4	

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? o Yes o No o Refused

4. Victim Information: eHIPS Victim Number: _____ **Exposure Date** ___/___/___ **Time** ____:____ **(military)**

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** o Male o Female **Status:** o Camper o Developmentally Disabled Camper o CIT/Jr. Counselor o Counselor o Other Staff* o Other* (Specify*)_____

Animal	Type of Exposure (select from back of form)	Animal	Type of Exposures (select from back of form)
#1		#3	
#2		#4	

Children's Camp Bat Exposure Incident Report

Report all bat exposure incidents involving campers, staff and other visitors.

Camp Name:_____ **Address:**_____

Facility type: o Day o Overnight o Municipal o Are 20% or more of the campers Developmentally Disabled

Exposure Date: __/__/__ **Time:** __:__ (Military time) **Report Date:** __/__/__ **eHIPS Log Number:** _____

If exposure was a result of a bat entering a building, were bat exclusion techniques utilized after the incident to prevent future bat entry and potential human exposure? Yes No

COMPLETE FOR **ALL** PERSON(S) INVOLVED IN THE EXPOSURE INCIDENT - See instructions on the back of this form.

1. Victim Information: Boxed Information is Confidential **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** Male Female **Status:** Camper Counselor Developmentally Disabled Camper CIT/Jr. Counselor Other Staff* Other* (Specify*) _____

Type of Exposure (select from back of form) |__| |__| |__| |__|

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? Yes No Refused

2. Victim Information: Boxed Information is Confidential **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** Male Female **Status:** Camper Counselor Developmentally Disabled Camper CIT/Jr. Counselor Other Staff* Other* (Specify*) _____

Type of Exposure (select from back of form) |__| |__| |__| |__|

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? Yes No Refused

3. Victim Information: Boxed Information is Confidential **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** Male Female **Status:** Camper Counselor Developmentally Disabled Camper CIT/Jr. Counselor Other Staff* Other* (Specify*) _____

Type of Exposure (select from back of form) |__| |__| |__| |__|

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? Yes No Refused

4. Victim Information: Boxed Information is Confidential **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Parent or Guardian Name_____ Home Phone Number (____) _____

Age: |__|__| **Sex:** Male Female **Status:** Camper Counselor Developmentally Disabled Camper CIT/Jr. Counselor Other Staff* Other* (Specify*) _____

Type of Exposure (select from back of form) |__| |__| |__| |__|

Was postexposure prophylaxis (PEP) recommended? o Yes o No Was PEP administered? Yes No Refused

---

Number of bats involved with the exposure incident: _____ **Number of bats captured & tested for rabies:** _____

Test results of Bats analyzed for rabies: (use additional sheets if necessary)

Bat #1 Positive Negative Untestable **Bat #3** Positive Negative Untestable

Bat #2 Positive Negative Untestable **Bat #4** Positive Negative Untestable

Instructions for Completing the Children's Camp Bat Exposure Incident Report

For each exposure incident, complete the requested information for all persons exposed and fax or email a copy to the Bureau of Community Sanitation and Food Protection within 24 hours of notification from the camp. A separate form must be utilized for each incident. The local health department Rabies Coordinator must be consulted to arrange for and determine the appropriateness of postexposure prophylaxis (PEP). A copy of the Children's Camp Bat Exposure Incident Report should be sent to the Rabies Coordinator for their records.

When an exposure is a result of a bat inside a building, the path of entry must be identified and the appropriate exclusion techniques to prevent future exposure(s) must be employed.

TYPE OF EXPOSURE - Using the coding scheme below, indicate the letter that corresponds to the type(s) of exposure; up to four letters may be selected, if appropriate.

Items A - M are exposure types that have a reasonable probability of transmitting rabies. In general, PEP is recommended for these exposures and the exposure must be reported by the camp.

A = Bite.
B = Scratch.
C = Saliva or nervous tissue contact.
D = Direct physical contact with live or dead bat.
E = Person touched bat without seeing the part of bat touched.
F = Bat flew into person and touched bare skin.
G = Bat flew into person on part of body with lightweight clothing and the person reports feeling an unpleasant sensation at the point of contact.
H = Person with bare feet stepped on bat.
I = Person awakens to find a bat in the room with them.
J = Live bat found in room with unattended infant, child, or person with sensory or mental impairment.
K = Person slept in small, closed-in camp cabin, bats swooping past while sleeping.
L = Bat found on ground near unattended infant, child, or person with mental impairment.
M = Unidentified flying object hits person and time of day (dusk or dawn), presence of mark where hit, and place where flying object came from (i.e., good site for roosting bats) all support likelihood that it was a bat.

The below exposure types are not likely to lead to rabies transmission. In general, PEP is <u>not</u> recommended for these exposures and no reporting is required by the camp.

- Person touches the back of a live bat while looking at it.
- Bat brushes past thick long hair of a teenager or adult and they are certain there was no skin contact.
- Person has contact with a completely dried-up carcass of a bat.
- Bats swoop past awake teenager or adult who does not feel it touch them.
- Dead bat found in cabin with no evidence that a person touched it.
- Bats are heard or seen in the walls or attic of cabin/house/office building.
- Bats are found in other parts of the cabin/house even if bedroom doors were open.
- Bats are heard or seen hanging from upper rafters of large A-frame cabin.
- Bat guano or other signs of bats are found in sleeping quarters.
- Bat found in sleeping quarters when no one is there sleeping or there is an awake adult who can verify that no exposure occurred.
- Bat flew into person and it hits a heavily clothed part of the body, and there was no unpleasant sensation at the point of contact.
- Live bat inside – no reasonable probability of human exposure.
- Live or dead bat outdoors – no reasonable probability of human exposure.

Children's Camp Inspector:_____ **Title:**_____

Local Health Department:_____ **Date:**__/__/____ **Telephone (**____**)**_____**-**_____

Date Rabies Coordinator Consulted about PEP Treatment: ____/____/____

Date Form Sent to Rabies Coordinator: ____/____/____

Instructions for Completing the Children's Camp Bat Exposure Incident Report

For each exposure incident, complete the requested information for all persons exposed and fax or email a copy to the Bureau of Community Sanitation and Food Protection within 24 hours of notification from the camp. A separate form must be utilized for each incident. The local health department Rabies Coordinator must be consulted to arrange for and determine the appropriateness of postexposure prophylaxis (PEP). A copy of the Children's Camp Bat Exposure Incident Report should be sent to the Rabies Coordinator for their records.

When an exposure is a result of a bat inside a building, the path of entry must be identified and the appropriate exclusion techniques to prevent future exposure(s) must be employed.

TYPE OF EXPOSURE - Using the coding scheme below, indicate the letter that corresponds to the type(s) of exposure; up to four letters may be selected, if appropriate.

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G = Bat flew into person on part of body with lightweight clothing and the person reports feeling an unpleasant sensation at the point of contact.
H = Person with bare feet stepped on bat.
I = Person awakens to find a bat in the room with them.
J = Live bat found in room with unattended infant, child, or person with sensory or mental impairment.
K = Person slept in small, closed-in camp cabin, bats swooping past while sleeping.
L = Bat found on ground near unattended infant, child, or person with mental impairment.
M = Unidentified flying object hits person and time of day (dusk or dawn), presence of mark where hit, and place where flying object came from (i.e., good site for roosting bats) all support likelihood that it was a bat.

The below exposure types are not likely to lead to rabies transmission. In general, PEP is <u>not</u> recommended for these exposures and no reporting is required by the camp.

- Person touches the back of a live bat while looking at it.
- Bat brushes past thick long hair of a teenager or adult and they are certain there was no skin contact.
- Person has contact with a completely dried-up carcass of a bat.
- Bats swoop past awake teenager or adult who does not feel it touch them.
- Dead bat found in cabin with no evidence that a person touched it.
- Bats are heard or seen in the walls or attic of cabin/house/office building.
- Bats are found in other parts of the cabin/house even if bedroom doors were open.
- Bats are heard or seen hanging from upper rafters of large A-frame cabin.
- Bat guano or other signs of bats are found in sleeping quarters.
- Bat found in sleeping quarters when no one is there sleeping or there is an awake adult who can verify that no exposure occurred.
- Bat flew into person and it hits a heavily clothed part of the body, and there was no unpleasant sensation at the point of contact.
- Live bat inside – no reasonable probability of human exposure.
- Live or dead bat outdoors – no reasonable probability of human exposure.

Children's Camp Inspector:_____ **Title:**_____

Local Health Department:_____ **Date:**__/__/____ **Telephone (**____**)**_____**-**_____

Date Rabies Coordinator Consulted about PEP Treatment: ____/____/____

Date Form Sent to Rabies Coordinator: ____/____/____

NEW YORK STATE DEPARTMENTOF HEALTH
Bureau of Community Sanitation and Food Protection

Children's Camp Summary of Illness Case Histories*

Name of Children's Camp	Date of Outbreak	eHIPS Incident #	Illness Information

			Status					Severity				Time of Initial Symptom			Signs and Symptoms									
No.	Name of Person	Bunk/Group	Camper	Counselor/Staff	Other	Sex	Age	Duration of Illness	Physician seen	Hospitalized	Death	Day	Hour	Incubation Period	Nausea	Vomiting	Abdominal Cramps	Diarrhea	Fever	Sore Throat				

Investigator	Title	Agency

* Follow Environmental Health Manual Procedure CSFP 803 for Foodborne Outbreaks

** **Maintain addresses and phone numbers for follow-up**

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DOH-61a (6/01)

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

Illness Report Form

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

A. FACILITY INFORMATION

Facility Name:_____ Facility Code:_____

Facility Type: Θ Day Θ Overnight Θ Municipal Day Camp Are 20% or more of the campers developmentally disabled? Θ Yes Θ No Date Reported ___/___/____

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

Type of Incident: Θ Illness Θ Illness Outbreak

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

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- 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 electronic report.

Information received by: _____ Title: _____

Report reviewed by: _____ Title: _____

N:\CAMPS\DOH61\illness.doc

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

Injury Report Form

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

A. FACILITY INFORMATION

Facility Name:_____ Facility Code:_____

Facility Type: Θ Day Θ Overnight Θ Municipal Day Camp Are 20% or more of the campers developmentally disabled? Θ Yes Θ No Date Reported ___/___/____

B. EVENT INFORMATION

eHIPS Incident Number: _____ **(Note: eHIPS will assign when entered into system)**

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-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:** Θ Female Θ Male **Status:** Θ Camper Θ Developmentally Disabled Camper Θ CIT/Jr. Counselor Θ Counselor Θ Other Staff* Θ Other* Specify _____

What was the victim doing? _____

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

* Specify_____

2. Multiple Victim Information- (Attach DOH-61b for multiple victim injury incidents)

Number of campers: male____ female____ **Number of staff:** male _____ female____ **Number of others:** male _____ female_____

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. For multiple victims, use form DOH-61b.

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 the location and type of treatment that person provided in the table below. Up to FOUR treatment providers may be indicated. For multiple victims, use form DOH-61b.

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* Specify _____

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. SUPERVISION AND CONTRIBUTING FACTORS

1. Supervision during incident (indicate as many as apply) ____ ____ ____ ____
   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 *
   * Specify _____

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- 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 Sanitation and Food Protection
Children's Camp Program

Multiple Victim Injury Report Form

Instruction: See Environmental Health Manual Procedure CSFP 146 and back of form prior to completing

Camp Name: _____ **eHIPS Incident Number:** _____

VICTIM INFORMATION: **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Name of Parent or Guardian (Last, First, M.I.) _____

Home Phone Number (_____) _____ **Shaded information is confidential

Age (years): _____ Sex: Θ Female Θ Male

Status: Θ Camper Θ Developmentally Disabled Camper Θ CIT/Jr. Counselor Θ Counselor
Θ Other Staff* _____ Θ Other*(Specify) _____

1. What was the victim doing? _____ (Select from back of form) Other* (specify) _____

2. Injury:

	Injury Type (question 2a)	*Specify (when required)	Area Injured (question 2b)	*Specify (when required)	Cause of Injury (question 2c)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

3. Treatment:

	Who (question 3a)	*Specify (when required)	Where (question 3b)	*Specify (when required)	What (question 3c)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

VICTIM INFORMATION: **eHIPS Victim Number:** _____

Name of Patient: (Last, First, M.I.) _____

Home Address: _____

Name of Parent or Guardian (Last, First, M.I.) _____

Home Phone Number (_____) _____ **Shaded information is confidential

Age: _____ Sex: Θ Female Θ Male

Status: Θ Camper Θ Developmentally Disabled Camper Θ CIT/Jr. Counselor Θ Counselor
Θ Other Staff* _____ Θ Other*(Specify) _____

1. What was the victim doing? _____ (Select from back of form) Other* (specify) _____

2. Injury:

	Injury Type (question 2a)	*Specify (when required)	Area Injured (question 2b)	*Specify (when required)	Cause of Injury (question 2c)	*Specify (when required)
First Injury						
Second Injury						
Third Injury						
Fourth Injury						

3. Treatment:

	Who (question 3a)	*Specify (when required)	Where (question 3b)	*Specify (when required)	What (question 3c)	*Specify (when required)
Treatment Provider #1						
Treatment Provider #2						
Treatment Provider #3						
Treatment Provider #4						

Instructions: **Use this form as a continuation of the DOH-61 form to collect injury information for multiple victims whose injuries are associated with a single event (i.e. vehicle collision)**

1. What was victim doing?

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

2. Injury

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 1A, 1B, and1C in the table on front page. Up to FOUR injuries can be indicated per victim.

A. Type of Injury:

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

B. Area Injured:

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

C. 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 *(Specify)

3. 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. Enter the information for questions 3A, 3B, 3C in the table on the opposite page.

A. 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*

B. 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*

C. What Treatment was 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 (*Specify how many in table on front)
z. Other*

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