

**2020**

**YOUTH CAMP**

**REGULATIONS**

**TRAINING PACKET**



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**IS MY  
PROGRAM A  
YOUTH CAMP?**



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Day Program Evaluation

<b>Program Name</b>		<b>Physical Address</b>		
<b>Contact Name</b>		<b>City</b>	<b>State</b>	<b>Zipcode</b>
<b>Phone #</b>		<b>Email Address</b>		
<b>Evaluation Questions</b>				
Question #	Question	1=YES 0=NO		
1	Does the program serve 7 or more children unrelated to the youth camp operator <sup>1</sup> {COMAR 10.16.06.02B(39)(a)(i)}?  Number of Children Served: _____			
2	Does the program serve children who range in age from 3 1/2 to 18 years old {COMAR 10.16.06.02B(7)}?  Age Range of Children Served: _____			
3	Does the program conduct 3 or more recreational activities <sup>2</sup> or any 1 specialized activity <sup>3</sup> {COMAR 10.16.06.02B(13)(c)}?  Recreational Activities: _____  Specialized Activities: _____			
4	Does the program operate for at least 7 calendar days during a 3-week period {COMAR 10.16.06.02B(13)(b)}?  Dates of Operation: _____  Number of Days in a 3-Week Period: _____			
5	Does the program conduct primarily recreational activities or a substantial outdoor recreational component <sup>4</sup> {COMAR 10.16.06.02B(39)(a)(ii)}?			
<b>TOTAL</b>				
<b>Is the program required to be licensed as a youth camp?</b>				
<b>If total is 5, then</b>		<b>If total is less than 5, then</b>		
YES		NO		

Evaluator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Footnotes

- [1] COMAR 10.16.06.02B (23) "Operator" means a person who owns, supervises, controls, conducts, or manages a youth camp.
- [2] COMAR 10.16.06.02B (29) Recreational Activity.
- (a) "Recreational activity" means a pleasurable, interesting, and entertaining activity.
  - (b) "Recreational activity" includes, but is not limited to:
    - (i) Structured or unstructured play;
    - (ii) A nature walk;
    - (iii) A field trip;
    - (iv) A sports activity;
    - (v) A game;
    - (vi) A hobby;
    - (vii) Music;
    - (viii) Drama;
    - (ix) Dance;
    - (x) Art;
    - (xi) A craft;
    - (xii) Except if for credit and taught by a certified teacher, a subject matter enrichment program;
    - (xiii) A specialized activity; or
    - (xiv) Instruction or skill development in an activity listed in §B(29)(b)(i)—(xiii) and (30) of this regulation.
- [3] COMAR 10.16.06.02B (39) "Specialized activity" means:
- (a) An adventure camp activity or program;
  - (b) An aquatic program;
  - (c) Archery;
  - (d) Artistic gymnastics;
  - (e) Firearms control;
  - (f) Hang gliding;
  - (g) High ropes;
  - (h) Horseback riding;
  - (i) Motorized vehicle activities;
  - (j) Rappelling;
  - (k) Riflery;
  - (l) Road cycling;
  - (m) Rock climbing;
  - (n) Skiing; and
  - (o) Spelunking.
- [4] COMAR 10.16.06.02B (34) "Substantial outdoor recreational component" means that 25 percent or more of a camper's time at camp is spent in outside recreational activities.

Evaluator's Siganture: \_\_\_\_\_ Date: \_\_\_\_\_



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Overnight Program Evaluation

Program Name		Physical Address		
Contact Name		City	State	Zipcode
Phone #		Email Address		
Evaluation Questions				
Question #	Question			1=YES 0=NO
1	Does the program serve 7 or more children unrelated to the youth camp operator <sup>1</sup> {COMAR 10.16.06.02B(45)(a)(i)}?  Number of Children Served: _____			
2	Does the program serve children who range in age from 3 1/2 to 18 years old {COMAR 10.16.06.02B(9)}?  Age Range of Children Served: _____			
3	During the program do children live apart from their relatives, parents or legal guardians for at least 5 consecutive days or 4 nights {COMAR 10.16.06.02B(35)}?  Dates of Operation: _____  Number of Days Apart: _____      Number of Night Apart: _____			
4	Does the program conduct primarily recreational activities <sup>2</sup> or have a substantial outdoor recreational component <sup>3</sup> {COMAR 10.16.06.02B(45)(a)(ii)}?			
TOTAL				
Is the program required to be licensed as a youth camp?				
If total is 4, then		If total is less than 4, then		
YES		NO		

Evaluator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes

- [1] COMAR 10.16.06.02B (28) "Operator" means a person who owns, supervises, controls, conducts, or manages a youth camp.
- [2] COMAR 10.16.06.02B (34) Recreational Activity.
- (a) "Recreational activity" means a pleasurable, interesting, and entertaining activity.
  - (b) "Recreational activity" includes, but is not limited to:
    - (i) Structured or unstructured play;
    - (ii) A nature walk;
    - (iii) A field trip;
    - (iv) A sports activity;
    - (v) A game;
    - (vi) A hobby;
    - (vii) Music;
    - (viii) Drama;
    - (ix) Dance;
    - (x) Art;
    - (xi) A craft;
    - (xii) Except if for credit and taught by a certified teacher, a subject matter enrichment program;
    - (xiii) A specialized activity; or
    - (xiv) Instruction or skill development in an activity listed in §B(34)(b)(i)—(xiii) and (39) of this regulation.
- [3] COMAR 10.16.06.02B (40) "Substantial outdoor recreational component" means that 25 percent or more of a camper's time at camp is spent in outside recreational activities.

Evaluator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YOUTH CAMP  
APPLICATION**



**NEW YOUTH CAMP APPLICATION FOR A  
YOUTH CAMP THAT WAS NOT ISSUED A CERTIFICATE  
OR LETTER OF COMPLIANCE IN THE PREVIOUS YEAR**

Maryland Department of Health (MDH)  
Environmental Health Bureau  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301, Baltimore, Maryland 21202-1608  
Phone 410-767-8417 Fax 410-333-8926  
Toll Free 1-877-4MD-DHMH ext. 8417

*** FOR OFFICE USE ONLY ***			
DATE RECEIVED	AMOUNT RECEIVED	CHECK NUMBER	IDENTIFICATION NUMBER
<p>INSTRUCTIONS: Maryland youth camp regulations (COMAR 10.16.06) require a youth camp operator to obtain a certificate or letter of compliance from the Maryland Department of Health (MDH) before the camp opens. Before a certificate or letter of compliance is issued, MDH must determine substantial compliance with the regulations.</p> <ul style="list-style-type: none"> <li>▶ Complete parts: A. through K. Retain a copy of the application for your records.</li> <li>▶ Enclose the initial application fee. Make check or money order payable to the Maryland Department of Health.</li> <li>▶ Mail the completed original application, fee and the required compliance documentation noted throughout the application to MDH <b>at least 60 days before the camp opens</b>. Do not fax the application.</li> <li>▶ If you operate multiple camps at separate physical locations, submit a separate application, fee and compliance documentation for each camp.</li> <li>▶ If you have questions or require assistance, please call MDH, Center for Healthy Homes and Community Services at the above numbers.</li> </ul>			
<b>A. OWNER/BUSINESS INFORMATION</b>			
1. BUSINESS NAME			
2. BUSINESS TYPE: (Choose One)		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CO-OWNERSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER:	3. FEIN (Required)
4. BUSINESS ADDRESS			
5. CITY, STATE, ZIP		6. COUNTRY <input type="checkbox"/> USA <input type="checkbox"/> OTHER:	
7. BUSINESS CONTACT NAME			
8. BUSINESS PHONE	9. OTHER PHONE	10. FAX	
11. BUSINESS CONTACT EMAIL			
<b>B. YOUTH CAMP INFORMATION</b>			
1. CAMP NAME			
2. CAMP PHYSICAL ADDRESS			
3. CITY, STATE, ZIP		4. MARYLAND COUNTY	
5. CAMP DIRECTOR'S NAME			
6. CAMP DIRECTOR'S PHONE	7. EMERGENCY PHONE	8. FAX	
9. CAMP DIRECTOR'S EMAIL			
10. CAMP MAIL ADDRESS: <input type="checkbox"/> SAME AS CAMP PHYSICAL ADDRESS ABOVE <input type="checkbox"/> SAME AS BUSINESS ADDRESS ABOVE			
ATTN (PERSON'S FIRST AND LAST NAME)		BUSINESS NAME	
ADDRESS			
CITY, STATE, ZIP		COUNTRY <input type="checkbox"/> USA <input type="checkbox"/> OTHER:	
11. CERTIFICATION TYPE (Check one) <input type="checkbox"/> Certificate <input type="checkbox"/> Letter of Compliance --(For bona fide religious organizations only.)			
12. CAMP TYPE (Check one)			
<input type="checkbox"/> Day Camp <input type="checkbox"/> Residential Camp <input type="checkbox"/> Day and Residential Camp <input type="checkbox"/> Trip Camp <input type="checkbox"/> Travel Camp			

**C. CURRENT CAMP PROGRAM INFORMATION. Attach current camp brochure.**

1. CAMP OPENING DATE	2. CAMP CLOSING DATE	3. DATE(S) CLOSED FOR BUSINESS
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**Attach fee with completed application. Make check payable to the Maryland Department of Health**

4. IS YOUR CAMP CURRENTLY ACCREDITED? (Check One, if Applicable)

NO                       YES

BY WHOM?

American Camp Association (ACA)

Boy Scouts of America (BSA)

*Attach a copy of current certification from the accrediting organization, no fee is required.*

INITIAL APPLICATION FEE FOR DAY CAMP  <b>\$190</b>	INITIAL APPLICATION FEE FOR RESIDENTIAL CAMP, DAY AND RESIDENTIAL CAMP, TRIP CAMP, OR TRAVEL CAMP  <b>\$500</b>
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**Payment of Fee Difference Owed.**

(1) The Department shall:

(a) Calculate a fee difference, that is, the difference between the fee paid at the time of application and the fee owed, based on information reported by a camp operator in the annual report for the past calendar year as required by Regulation .06 of COMAR 10.16.06 and the fees found in COMAR 10.01.17; and

(b) Notify a camp operator of any fee owed to the Department.

(2) Within 2 weeks following receipt of the notice from the Department, the camp operator shall pay the fee owed to the Department.

FEE CHART FOR DAY CAMP	FEE CHART FOR RESIDENTIAL CAMP, DAY AND RESIDENTIAL CAMP, TRIP CAMP, OR TRAVEL CAMP
1 to 500 CAMPER DAYS : \$190 501 to 2,000 CAMPER DAYS: \$500 2,001 to 5,000 CAMPER DAYS: \$665 5,001 or more CAMPER DAYS: \$855	1 to 700 CAMPER DAYS : \$500 701 to 5,000 CAMPER DAYS: \$1,000 5,001 to 16,000 CAMPER DAYS: \$1,500 16,001 or more CAMPER DAYS: \$2,000

5. FEE ENCLOSED \$ \_\_\_\_\_

**D. YOUTH CAMP FACILITY INFORMATION**

1. ARE YOU OPERATING A CHILDCARE CENTER AT THIS SITE?                       NO                       YES *Attach a copy of license.*

2. DID YOU NOTIFY THE CHILD CARE LICENSING OFFICE ABOUT YOUR INTENT TO OPERATE A YOUTH CAMP AT THIS SITE?

NO                       YES *Attach documentation of the notification.*                       NOT APPLICABLE

3. BUILDING(S) TYPE                      (Check all that apply.)

School (Public or Private) or Government Owned Building: *Attach completed Building Safety form.*

Privately Owned Building or Property *Attach a copy of a current Fire Safety Inspection (COMAR 10.16.06.42) from the State or Local Fire Marshal's Office.*

*Attach the Use & Occupancy permit. If no Use & Occupancy permit, attach certification from a master electrician and a master plumber stating the building meets code and attach documentation of zoning approval.*

Outdoor Pavilion or No Buildings.

Other, Specify Type: \_\_\_\_\_ *Contact this Office for required compliance documentation.*

4. WATER SUPPLY – **COMAR 10.16.06.36**

Public: *Specify the water company from your water bill:* \_\_\_\_\_

On-Site Well: *Attach completed Local Health Approval form.*

5. SEWAGE DISPOSAL – **COMAR 10.16.06.37**

Public: *Specify the sewer service company:* \_\_\_\_\_

On-Site Sewage Disposal System: *Attach completed Local Health Approval form.*

**6. BATHROOM FACILITIES - COMAR 10.1606.38 and .39 (Check all that apply.)**

Male  Toilets, # \_\_\_\_\_  Handsinks, # \_\_\_\_\_  Showers, # \_\_\_\_\_  Urinals, # \_\_\_\_\_

Female  Toilets, # \_\_\_\_\_  Handsinks, # \_\_\_\_\_  Showers, # \_\_\_\_\_

Portable Toilets  Male, # \_\_\_\_\_  Female # \_\_\_\_\_ **Attach completed Local Health Approval form.**

Privies  Male, # \_\_\_\_\_  Female # \_\_\_\_\_ **Attach completed Local Health Approval form.**

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**7. CAMP FACILITIES - COMAR 10.16.06.40 and .41 (Check all that apply.)**

Sleeping Facilities  Tents  Cabins  Other, specify: \_\_\_\_\_

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**8. FOOD SERVICE - COMAR 10.16.06.42 (Check all that apply.)**

Meals Prepared On-Site: **Attach copy of food permit.**

Lunches Brought From Home:  Refrigeration provided  Notice to send non-perishable food given to parents

Summer Lunch Program: **Attach verification of acceptance from certifying organization.**

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**9. PRIMITIVE CAMP A youth camp where permanent facilities for water supply and sewage disposal systems, food service facilities, sleeping areas, bathing facilities, and hand washing facilities are not available. (If your camp or any portion of your camp is a primitive camp, check all that apply.)**

No Permanent Facility for Water Supply System: **Attach the camp's written procedure for water filtration and disinfection (COMAR 10.16.06.36).**

No Permanent Facility for Sewage Disposal System: **Attach the camp's written procedure for sewage disposal (COMAR 10.16.06.37).**

No Permanent Facility for Food Service: **Attach the camp's written food preparation and handling plan (COMAR 10.16.06.42).**

No Permanent Facility for Sleeping Areas: **Attach description of the camp's sleeping provisions (COMAR 10.16.06.40 and .41).**

No Permanent Facilities for Bathing or Hand Washing: **Attach the camp's written bathing or hand washing procedures (COMAR 10.16.06.38 and .39).**

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**E. HEALTH PROGRAM INFORMATION**

1. HEALTH SUPERVISOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

2. HEALTH SUPERVISOR'S TITLE (Check one) \_\_\_\_\_ MD LICENSE # \_\_\_\_\_

Physician  Registered Nurse  Certified Nurse Practitioner

3. DO 50% OR MORE OF THE CAMPERS HAVE IDENTIFIED MEDICAL PROBLEMS?  NO  YES

4. THE HEALTH SUPERVISOR IS: **COMAR 10.16.07.04 (Check one)**

Available for consultation at all times when campers are present.

On-site at all times when campers are present. **Required when 50% or more of the campers have identified medical problems.**

5. WRITTEN HEALTH PROGRAM **Attach a copy of the camp's health program that includes the health supervisor's annual approval. (COMAR 10.16.07.03 and .14)**

6. CAMPER HEALTH RECORD **Attach example of the camp's camper health record form. (COMAR 10.16.07.08)**

7. STAFF HEALTH RECORD **Attach example of the camp's staff member/volunteer health record form. (COMAR 10.16.07.09)**

8. HEALTH LOG IS: (COMAR 10.16.07.05) (Check one)

Bound composition book  Spiral notebook  Individual record  Electronic medical record

9. CPR CERTIFIED STAFF **Two adults with current cardiopulmonary resuscitation (CPR) certification are required on duty at camp at all times.**  
 Number of adult staff certified in CPR by a national certifying organization: (COMAR 10.16.07.04) \_\_\_\_\_

10. FIRST AID CERTIFIED STAFF **Two adults with current first aid are required on duty at camp at all times.**  
 Number of adult staff certified in first aid by a national certifying organization: (COMAR 10.16.07.04) \_\_\_\_\_

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**F. EMERGENCY PROCEDURES INFORMATION.**

**Attach a copy of the camp's emergency procedures. (COMAR 10.16.06.34)**

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**G. CHILD ABUSE PREVENTION AND REPORTING**

**Attach a copy of the camp's child abuse prevention and reporting procedures. (COMAR 10.16.06.35)**

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**H. CRIMINAL BACKGROUND CHECK INFORMATION. (COMAR 10.16.06.21)**

1. PERSONNEL ADMINISTRATOR NAME (FIRST AND LAST): \_\_\_\_\_

2. PERSONNEL ADMINISTRATOR PHONE NUMBER: \_\_\_\_\_

3. DOES THE PERSONNEL ADMINISTRATOR HAVE A CRIMINAL BACKGROUND INVESTIGATION ON FILE WITH MDH?  Yes  No

4. HAS THE PERSONNEL ADMINISTRATOR COMPLETED THE CONSENT FOR RELEASE OF INFORMATION/BACKGROUND CLEARANCE REQUEST FORM FROM MARYLAND CHILD PROTECTIVE SERVICES?  Yes  No

**Attach Release Form to completed application, must have original signature and notary.**





**4. SUPERVISION PROVIDED DURING ROUTINE ACTIVITIES** See COMAR 10.16.06.54. *If necessary, attach additional sheet.*

CAMPERS AGE	GROUP SIZE	NUMBER OF ADULT (S) (18 AND OLDER) SUPERVISING CAMPER GROUP	NUMBER OF ASSISTANT COUNSELORS (16-17 YEAR OLDS) SUPERVISING CAMPER GROUP

**J. WORKER'S COMPENSATION ACT COMPLIANCE STATEMENT** Indicate compliance with workers compensation act.

Maryland Health-General Code Annotated §1-202 requires that before any license, certificate or permit may be issued under the Health-General Article; the employer must file a certificate of compliance listing a workers' compensation insurance policy or binder number. This statement of compliance is based on the workers' compensation law applicable in the state in which the licensee is based. **(Check one and provide requested information.)**

- I have workers' compensation insurance.  
 Insurance Company \_\_\_\_\_  
 Policy or Binder number \_\_\_\_\_
- Attach a copy of the certificate of compliance with the Maryland Workers' Compensation Act.

**K. YOUTH CAMP REGULATIONS (COMAR 10.16.06) COMPLIANCE STATEMENT.** *Read and sign compliance statement.*

I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or COMAR 10.16.06, adopted by the Department under this subtitle may result in an abatement order or closure order or denial, suspension, or revocation of youth camp certification or letter of compliance. *If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-MDH ext. 78417.*

**X** \_\_\_\_\_ **DATE**

**APPLICANT'S SIGNATURE:** *Must be a person who owns, supervises, controls, conducts, or manages a youth camp.*

This document can be found on the MDH website at:  
<https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Youth%20Camps/ApplicationforNewYouthCamp.pdf>



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camp Application Fee Chart

Youth camp application fees are based on "Camper Days". Camper Days means the number of campers attending each day and each day's total added together. Example: 10 campers attending 5 days equals 50 "camper days".

<b>Day Camp Fees</b>		
Day Camp is a program campers attend daily, no overnights.		
<b>Camper Days</b>	<b>Regular Fee</b>	<b>Good Standing (Reduced Fee)</b>
1 to 500	\$190	\$45
501 to 2,000	\$500	\$125
2,001 to 5,000	\$665	\$165
5,001 or more	\$855	\$215
<b>Residential, Day &amp; Residential, Travel or Trip Camp Fees</b>		
Residential Camp is a program where campers stay overnight. Day & Residential Camp is a program that includes both day campers and overnight campers. Travel Camp is a program that is overnight and motorized transportation is used to move the campers among sites. Trip Camp is a program that is overnight and the camper moves from one site to another under their own power or by transportation that permits individual guidance of a vehicle or animal.		
<b>Camper Days</b>	<b>Regular Fee</b>	<b>Good Standing (Reduced Fee)</b>
1 to 700	\$500	\$125
701 to 5,000	\$1,000	\$250
5,001 to 16,000	\$1,500	\$375
16,001 or more	\$2,000	\$500

**Good Standing (Reduced Fee) as defined in COMAR 10.16.06.02B**

(17) "Good standing" means:

(a) Compliance with the:

- (i) Annual report and self-assessment submission requirements as specified in Regulation .06 of this chapter; and
- (ii) Application procedure and fee requirements as specified in Regulation .08 of this chapter; and

(b) A camp that in the previous calendar year paid the application fee as set forth in COMAR 10.01.17.02; and

(c) Had no critical violations of this chapter found by the Department during an inspection:

- (i) In the last 2 calendar years; or
- (ii) For a camp in good standing, in the last calendar year that an inspection took place.

(11) "Critical violation" means failure to comply with:

- (a) Regulation .07 of this chapter; (*Certification or Letter of Compliance*)
- (b) Regulation .10 of this chapter; (*Time period for correction of violations*)
- (c) Regulation .21 of this chapter; (*Background checks and clearances*)
- (d) COMAR 10.16.07.03A(1) and (2); (*Health plan approved annually, present at camp*)
- (e) A majority of the required procedures in COMAR 10.16.07.03A(4) and (5); (*Health plan/medication procedures*)
- (f) COMAR 10.16.07.04; (*Health Supervisor and 2 staff with CPR and First Aid*)
- (g) COMAR 10.16.07.08A—C; (*Camper health form – Doctor, health issues, Parent/Emergency contact*)
- (h) A majority of the required procedures in Regulation .34A of this chapter; (*Emergency Plan*)
- (i) A majority of the required procedures in Regulation .35B of this chapter; (*Child Abuse Prevention and Reporting*)
- (j) Regulation .46A(1) and (2) of this chapter; (*Fire – compliance and fire marshal inspection*)
- (k) Regulation .47C and F(6)—(9) of this chapter; (*Swimming and watercraft supervision*)
- (l) Regulation .48D(1) of this chapter; (*Riflery and airgun supervision*)
- (m) Regulation .49C of this chapter; (*Archery supervision*)
- (n) Regulation .50B of this chapter; (*Horseback riding supervision*)
- (o) Regulation .51B of this chapter; (*Other specialized activity supervision*)
- (p) Regulation .52A(1) and B(1) of this chapter; (*Safety plans for all specialized activities/trips, director is present*)
- (q) A majority of the required procedures in Regulation .52A(2)—(5) of this chapter; (*Specialized activities and trips*)
- (r) Regulation .53A(1) and (2) of this chapter; or (*Transportation – State law, safety plan*)
- (s) Regulation .54 of this chapter. (*Routine supervision*)



**CRIMINAL  
BACKGROUND  
CHECKS  
AND  
BACKGROUND  
CLEARANCES**



**CRIMINAL HISTORY  
RECORD CHECK FOR  
PERSONNEL AT YOUTH CAMPS**

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301, Baltimore, MD 21202-1608  
(410) 767-8417 Fax (410) 333-8926  
Toll Free 1-877-463-3464 ext 78417

A camp operator must comply with the Family Law Article, §§ 5-560-568, Annotated Code of Maryland, regarding criminal history record checks for employees and employers of facilities that care for or supervise children. Fingerprint-supported criminal history record checks are done through the Maryland Public Safety and Correctional Services, Criminal Justice Information System (CJIS). **Background checks through other sources are not accepted in lieu of completing CJIS criminal history record checks.** The employer must be able to show the Maryland Department of Health representative the criminal history record check. The employer must keep on file for each employee the results of the criminal history record check, a signed privacy statement and a copy of the Livescan Pre-Registration Application.

**CJIS STOREFRONT FINGERPRINTING CENTER** is located at the Reisterstown Road Plaza Office Complex, 6776 Reisterstown Road, Suite 102, Baltimore, Maryland. Hours of operation are Monday through Friday 8:30 a.m. to 5:00 p.m. Phone: 410-764-4501 or 1-888-795-0011, Monday through Friday, 8:00 a.m. to 5:00 p.m. Web site: <http://dpscs.maryland.gov/publicservs/>

**AUTHORIZATION NUMBER** - If the employer does not have a CJIS authorization number, complete the "General Registration Form" and submit to CJIS via fax or mail. *Provide an email address that will be used to receive the criminal history results.* The CJIS Central Repository will contact you via email to complete the documents necessary to issue your authorization number. Notify CJIS immediately of any changes in your contact information using the "Registration Update Form". Both forms can be found on the CJIS website at: <http://dpscs.maryland.gov/publicservs/bgchecks.shtml>.

**CRIMINAL HISTORY RECORD CHECK APPLICATIONS** – Once you have an authorization number and **before the employee works at the camp** submit an application for criminal history record check to CJIS Central Repository using the Livescan Pre-Registration Application.

**LIVESCAN PRE-REGISTRATION APPLICATION** – The application may be submitted electronically using scanned fingerprints by using the CJIS Storefront Fingerprinting Center, a CJIS MVA fingerprinting site, or an approved private provider. There is a link to the Livescan Pre-Registration Application form online at: <http://dpscs.maryland.gov/publicservs/fingerprint.shtml>.

**The ORI #: MD004455Y is required and the reason fingerprinted is CHILD CARE**

**CRIMINAL HISTORY RECORD CHECK FOR EMPLOYEES OUTSIDE MARYLAND** –

1. Write to CJIS-Central Repository P.O. Box 32708, Pikesville, Maryland 21282-2708, or call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request a fingerprint card. Have your fingerprints professionally inked on the card. **Write the camp/employer Authorization number on the card.**
2. Mail the fingerprint card and associated fee to CJIS-Central Repository P.O. Box 32708 Pikesville Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
3. Include a check made out to "CJIS Central Repository". See the schedule of Associated Fees at <http://dpscs.maryland.gov/publicservs/bgchecks.shtml#fees>.
4. You may expect a response in 10 - 15 business days.

**Add "ORI #: MD004455Y" and "CHILD CARE" to the upper right hand corner of the card.**

**EMPLOYEES** –When completing the Livescan Pre-Registration Application, employees must use the camp employer's authorization number.

**PERSONNEL ADMINISTRATOR** – Each camp must have a personnel administrator with a background check on file with MDH-CHHCS. The personnel administrator may be the owner, director, or a human resources staff member who reviews the background check results and determines if an individual may work at camp: The personnel administrator must complete his/her background check using the MDH authorization number (9400019171) and the ORI number (MD004455Y).

**FINGERPRINTS** – Electronic fingerprinting is available at the CJIS Storefront Fingerprinting Center. The cost is \$20.00 per person. Please arrive at least one half hour before closing. Fingerprinting services are available from private providers authorized by CJIS. A list of providers is online at <http://dpscs.maryland.gov/publicservs/fingerprint.shtml> . Check with the private provider for their fingerprinting fees which are separate from the processing fee.

**FEES** - The processing fee for an application is \$31.25. This does not include the fingerprint fee. The fee is reduced to \$29.25 for “volunteers” please see details below. The CJIS Storefront Fingerprinting Center does not accept cash. All fees must be paid by credit card (Master Card, Visa, and Discover) or check. Checks submitted to CJIS Central Repository are electronically processed by TeleCheck Electronic Check Acceptance (ECA®). For more information regarding electronic check acceptance visit <http://www.firstdata.com/telecheck/telecheck-works.htm>.

**RESULTS** –Call CJIS Customer Service at (410) 764-4501 or 888-795-0011 for help if you do not receive the Maryland or FBI criminal history record information in 48 hours. You receive the results through a secure email system where you must login to access the results. Keep the original results in a secure manner on file at the camp office.

**REJECTED FINGERPRINTS** – If the employee’s fingerprints are rejected because of poor quality, the employer and employee will be notified. Reprints must be received within 60 days of the date on the reject letter or the employee must reapply and pay application and fingerprinting fees.

**365 DAY REQUEST** – When the employee has completed a criminal history record check for another child care employer within the past year, the 365 Day Request form may be used instead of the full application with fingerprints. There is no cost for processing a 365 Day Request. Fingerprints are not required. CJIS **must** process the form within 365 calendar days of CJIS's receipt of the employee’s original application.

**RETURNING EMPLOYEE** – A repeat criminal history record check is not required if the original result with the camp listed as the employer is on file at camp and there is a contractual agreement for the employee to return to duty and there has not been a termination of employment.

**EMPLOYEES UNDER AGE 18** - The criminal history record check is required for employees under age 18. CJIS accepts applications for any person 14 years old or older.

**VOLUNTEERS** - An employer at a youth camp may ask volunteers to apply for a criminal history record check, but **this is not required**. Please call CJIS at (410) 764-4501 for additional information. The FBI fee is reduced as long as the word "CHILD CARE/VOLUNTEER" is written on the application in the Reason Fingerprinted box. The CJIS-015 purple form must be checked “STATE AND FBI VOLUNTEER”. The total fee is \$29.25.



# Department of Public Safety & Correctional Services

## Fingerprinting Services / Fingerprinting Courses

<http://dpscs.maryland.gov/publicservs/fingerprint.shtml>

### Commercial Fingerprinting Services (Private Providers)

Private providers are authorized by COMAR Regulation 12.15.05 to submit fingerprints directly to the Maryland Criminal Justice Information System for the purpose of obtaining criminal history record checks. Criminal history record information obtained under this program is mailed directly to you or the agency(s) of your choice. No information regarding your criminal history is given to the private provider. In addition to the fees required by the State of Maryland for criminal history record checks the private provider will collect an additional service fee as determined by the provider.

### CJIS Operated Fingerprinting Services

Location: 6776 Reisterstown Road  
(West side of Reisterstown Road Plaza Mall)  
Suite 102 (first floor)  
Baltimore, MD 21215  
For directions, go to <http://www.mapquest.com>

Phone: 410-764-4501  
1-888-795-0011 (toll free)

Hours of Operation Monday-Friday 8:30a-5pm

**Please contact any one of the Private Providers listed above for the late evening and weekend operation hours they provide.**

**Closed on designated State holidays**

**The following locations are available by appointment only:**

Motor Vehicle Administration - Bel Air

501 West MacPhail Road

Bel Air, MD 21014

Motor Vehicle Administration - Frederick

1601 Bowman's Farm Rd.

Frederick, MD 21701

Motor Vehicle Administration - Waldorf

St. Charles Business Park

11 Industrial Park Drive

Waldorf, MD 20602

Motor Vehicle Administration - Salisbury

251 Tilghman Rd

Salisbury, MD 21801

Motor Vehicle Administration - Glen Burnie

6601 Ritchie Hwy, N.E.

Glen Burnie, MD 21062

Call for an appointment: 410-764-4501 or 1-888-795-0011 (toll free)

**Government Operated Services**

<b>AGENCY</b>	<b>ADDRESS</b>	<b>PHONE</b>
<u>Annapolis Police Department</u>	199 Taylor Avenue Annapolis, MD 21401	410.268.9000
<u>Berlin Police Department</u>	10 William Street Berlin, MD 21811	410.641.1333
<u>Cecil College Public Safety Department</u>	1 Seahawk Dr. North East MD 21901	410.287.1619
<u>Charles County Sheriff's Office</u>	11110 Mall Circle Waldorf, MD 20603	301.609.6438
<u>Cecil county sheriff's Office</u>	107 Chesapeake Blvd. Elkton, MD 21921	410.392.2118
<u>Frederick County Sheriff's Office</u>	110 Airport Drive East Frederick, MD 21701	301.600.4058
Frostburg State University Police	101 Braddock Road Frostburg, MD 21532	301.687.4223
<u>Garrett County Sheriff's Office</u>	311 E Alder St Oakland MD 21550	301-334-5040
<u>Glenarden Police Department</u>	8600 Glenarden Parkway Glenarden, MD 20706	301.772.3214
<u>Harford County Sheriff's Office Headquarters</u>	45 South Main Street Bel Air, MD 21014	410.836.5470
<u>Harford County Sheriff's Office Northern Precinct</u>	3726 Norrisville Road Jarrettsville, MD 21084	410.692.7880
<u>Harford County Sheriff's Office Southern Precinct</u>	1305 Pulaski Highway Joppa, MD 21085	410.612.1717
<u>Laurel Police Department</u>	811 Fifth St. Laurel, MD 20707	301.498.0092

<b>AGENCY</b>	<b>ADDRESS</b>	<b>PHONE</b>
Queen Anne's County Sheriff's Office	505 Railroad Ave. Centreville, MD 21617	410.758.0770
<u>Salisbury University Police Fingerprint Services - EC149</u>	110 Power Street Salisbury, MD 21801	410.548.2900
<u>St. Mary's County Sheriff Office</u>	23150 Leonard Hall Drive Leonardtown, MD 20650	301.475.8008
<u>Rockville City Police Department</u>	2 W. Montgomery Avenue Rockville, MD 20850	240.314.8924
<u>UMBC Police Department</u>	1000 Hilltop Circle Baltimore, MD 21250	410.455.1685
<u>University of Maryland, College Park</u>	Department of Public Safety Pocomoke Building 7569 Baltimore Avenue College Park, MD 20742	301.405.5758

**FOR FAST AND ACCURATE SERVICE**

1. If you are requesting a background check for employment or licensing purposes you must have an agency name and authorization number
2. If your background check is being sent to a government agency you may also need an ORI number.
3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification)
4. Fill out the attached form, print it and bring it to any fingerprinting center.  
Livescan Pre-registration Application
5. Bring payment as indicated below. Major credit cards and checks are accepted. Cash and money orders are not accepted at the State Operated Fingerprinting Centers.

**Associated CJIS - CR Fees**

Fees are required to process each criminal background record check request.

**All fees must be paid by credit card or check in United States currency. The Central Repository cannot accept cash.**

Full background [state and FBI] for authorized agencies only	\$31.25
child care volunteers	\$29.25
Maryland Mentor	\$15.00 with certification card
State background check only	\$18.00
with Gold Seal	\$19.00
Criminal Justice	
full background	No fee
state only	No fee
Attorney/Client civil	\$18.00
Attorney/Client pending criminal case	No fee

**There is a \$20.00 fingerprint service fee per customer. There is a maximum of five ink cards printed per customer. You may choose to have your fingerprints taken at another agency. Make sure to check with that agency for their fingerprinting fees, as fees may vary. At all CJIS locations money orders are no longer accepted for processing the application for background check requests.**















**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** (PLEASE TYPE OR PRINT CLEARLY)

Name:					
Date of birth:		SSN:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)	
Height: ft.	inches	Weight: lbs.	Eye Color:		Hair Color:
Race: <input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American	<input type="checkbox"/> Other (Please check)	
Place of Birth:			Citizenship:		
Current address:					
City:			State:		ZIP Code: -
Daytime Phone:		Evening Phone:		Driver's License #:	

**AGENCY INFORMATION**

Agency Authorization #:	
ORI # (if required): MD004455Y	Reason fingerprinted? CHILD CARE
Position Applied for:	
Request Type: (Choose one ONLY)	
<input type="checkbox"/> Adult Dependent Care	<input type="checkbox"/> Government Licensing or Certification
<input type="checkbox"/> Attorney/Client	<input type="checkbox"/> Immigration/VISA
<input checked="" type="checkbox"/> Child care	<input type="checkbox"/> Individual Challenge
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Individual Review
<input type="checkbox"/> Gold Seal/ Adoption	<input type="checkbox"/> MSP Licensing
<input type="checkbox"/> Gold Seal/Letter/VISA	<input type="checkbox"/> Private Party Petition
<input type="checkbox"/> Government Employment	<input type="checkbox"/> Public Housing

**Mail Response to:**

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:	_____
Address:	_____
City, State, Zip code:	_____



For Camp Personnel Administrator

DHMH Authorization #



**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** (PLEASE TYPE OR PRINT CLEARLY)

Name:			
Date of birth:	SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please check)			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

**AGENCY INFORMATION**

Agency Authorization #: 9400019171	
ORI # (if required): MD004455Y	Reason fingerprinted? CHILD CARE
Position Applied for:	

<b>Request Type:</b> (Choose one ONLY) <input type="checkbox"/> Adult Dependent Care <input type="checkbox"/> Attorney/Client <input checked="" type="checkbox"/> Child care <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Gold Seal/ Adoption <input type="checkbox"/> Gold Seal/Letter/VISA <input type="checkbox"/> Government Employment	<input type="checkbox"/> Government Licensing or Certification <input type="checkbox"/> Immigration/VISA <input type="checkbox"/> Individual Challenge <input type="checkbox"/> Individual Review <input type="checkbox"/> MSP Licensing <input type="checkbox"/> Private Party Petition <input type="checkbox"/> Public Housing
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**Mail Response to:**

(Mailing option only available for Visa, Gold Seal and/or Individual Review)

Name:	_____
Address:	_____
City, State, Zip code:	_____





STATE OF MARYLAND  
 DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
 CENTRAL REPOSITORY  
 P.O. BOX 32708  
 PIKESVILLE, MD. 21282-2708

**365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK**

NAME \_\_\_\_\_  
 (Last) (First) (MI)

ADDRESS \_\_\_\_\_  
 (Number) (Street) (P.O. Box)  
 \_\_\_\_\_  
 (City) (State) (Zip Code)

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

\_\_\_\_\_ (12 DIGIT NUMBER)

**I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.**

SIGNATURE OF EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_

\*\*\*\*\*

**TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.**

\_\_\_\_\_  
 (EMPLOYER NAME)  
 \_\_\_\_\_  
 (ADDRESS)  
 \_\_\_\_\_  
 (CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: \_\_\_\_\_

AUTHORIZED SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

\*\*\*\*\*

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32708, PIKESVILLE, MD. 21282-2708  
 Customer Assistant Desk: (410) 764-4501 Fax#: 410-653-5690 Alt. Fax#: 410-653-6320

\*\*\*\*\*

**FOR CJIS CENTRAL REPOSITORY USE ONLY**

- This request can not be processed because:
- \_\_\_\_\_ this is not a valid reference number
  - \_\_\_\_\_ this is not a valid authorization number
  - \_\_\_\_\_ this reference number has not been received at the Central Repository
  - \_\_\_\_\_ this authorization number is not approved for this request.
  - \_\_\_\_\_ the application associated with this reference number was received more than 365 days before receipt of this request.
  - \_\_\_\_\_ requested information is not completed





## **CHILD PROTECTIVE SERVICES BACKGROUND CLEARANCE FOR PERSONNEL AT YOUTH CAMPS**

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301, Baltimore, MD 21202-1608  
(410) 767-8417 Fax (410) 333-8926  
Toll Free 1-877-463-3464 ext 78417

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Youth camps are required to obtain a background clearance response from Child Protective Services to determine if an individual may be employed at camp. In May 2017, Maryland Department of Human Resources, DHR, (the agency has since been renamed Maryland Department of Human Services, DHS) created an online portal to facilitate the submission and processing of Child Protective Services (CPS) Background Clearance Requests for youth camps. DHS and Maryland Department of Health, MDH, are requiring that all CPS background clearances are completed through this online portal.

### **PERSONNEL ADMINISTRATORS**

The Certification for Youth Camps regulations, COMAR 10.16.06.21, require a youth camp operator to ensure that the Maryland Department of Health has a background clearance from Child Protective Services on file for the camp's Personnel Administrator.

**Each camp Personnel Administrator needs to create an account in myDHRbenefits.**

**<https://mydhrbenefits.dhr.state.md.us/dashboardClient/#/home>**

Complete all required information, marked with an asterisk. Answer Yes to the question: Are you applying for yourself?

After creating your account complete the CONSENT FOR RELEASE OF INFORMATION CPS BACKGROUND/ADAM WALSH BACKGROUND CLEARANCE REQUEST form online.

1. Open the form by clicking on the Organization Employee Clearance button,
2. Under Part 1: PURPOSE OF SEARCH, B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO: Pick the button for Youth Camp Personnel Administrator,
3. Fill in all required information,
4. Add the camp name in Organization Name,
5. The County/City/Agency will auto fill and cannot be changed,
6. If you have a Social Security number, include it on the form, if you do not have a Social Security number you may leave blank,
7. Review to make sure all information is correct and save, you cannot make changes after you save, to correct you will need to open a new form and complete again,
8. Print the completed form,
9. Sign the form before a notary,
10. There is no fee from DHS for this service,
11. Personnel Administrators mail the original form to MDH, 6 St Paul Street, Suite 1301, Baltimore MD 21202-1608.

If you have multiple camp locations or licenses, please ensure that each camp is associated with your myDHR account. The Maryland Department of Health will pass this information on to DHS to have the Personnel Administrator's account upgraded to Personnel Administrator Status. Once this occurs the Personnel Administrator will be able to scan the notarized forms into the electronic system and submit it to DHS for processing.

The Personnel Administrator can track applications submitted through the system and see the current status of each application at any given time.

## YOUTH CAMP EMPLOYEES

The Personnel Administrator can either enter the information for each employee or have the employee create their own myDHR account and enter the information themselves.

<https://mydhrbenefits.dhr.state.md.us/dashboardClient#/home>

1. Complete the CONSENT FOR RELEASE OF INFORMATION CPS BACKGROUND/ADAM WALSH BACKGROUND CLEARANCE REQUEST form online.
2. Open the form by clicking on the Organization Employee Clearance button.
3. Under Part 1: PURPOSE OF SEARCH, B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO: Pick the button for Youth Camp Worker/Volunteer.
4. Select the camp where the employee is working by using the drop down boxes for County, then City and Camp Name, if working at multiple camps for the same employer select only one camp, you will not have to submit for each camp. (If the employee works at camps with different employers, complete the form separately for each employer.) If you cannot find the camp in the list, contact MDH for assistance.
5. Fill in all required information.
6. If you have a Social Security number, include it on the form, if you do not have a Social Security number you may leave blank.
7. Review to make sure all information is correct and save, you cannot make changes after you save, to correct you will need to open a new form and complete again.
8. Print the completed form.
9. The employee then signs the form in front of a notary. If the employee is under 16 years old, the parent/guardian must also sign in front of the notary.
10. Submit the original signed form to the camp Personnel Administrator. The original for the employee is kept at the camp, not mailed to DHS or MDH.
11. There is no fee from DHS for this service.

The Personnel Administrator scans and saves the notarized form on their computer. Please name the file LASTNAME FIRSTNAME. For example: Smith John.

The Personnel Administrator submits the application to DHS for processing by logging into their myDHR account. Under the Home tab, select Saved in the drop down box, then locate the employee's application and click Open. Look for the section on the page labeled **File Upload** and click on the Add button. Then browse to find the document saved on your computer, then click Save. Check the box next to **Notarized Document received and attached**. Under Decision Type select Submitted. At the bottom click on the Complete button

**Keep the signed/notarized CPS form at the camp, do not mail to MDH or DHS.**

Once processed the result will be emailed to the Personnel Administrator or can be viewed in their myDHR account.

If a form was saved with missing or incorrect information, it cannot be edited or changed, a new form is completed, see number 7 above. The Personnel Administrator should find the incorrect form under the saved applications and under Decision Type select Application Voided.

**Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps**

**Child Protective Services Background Clearance Form  
Frequently Asked Questions**

- 1. What is the difference between the Child Protective Services Background Clearance and the Maryland and FBI criminal background checks?**
  - a. The Child Protective Services Background Clearance provides information from the Department of Human Resources statewide database regarding child abuse and neglect that may not show up on a Maryland or FBI criminal background check.
  
- 2. Who must sign the Child Protective Services Background Clearance form if the employee is a minor?**
  - a. DHR/Social Services will accept the form signed by a minor, who is 16 years old or older, without a parent legal guardian signature.
  - b. DHR/Social Services will only accept the form from a minor, who is 15 years old or younger, if both the minor and the parent or guardian signs the form.
  
- 3. Why must the Child Protective Services Background Clearance form be notarized?**
  - a. The form must be notarized because it is a legal document giving Child Protective Services the ability to release the requested information to the person or entity listed on the form.
  
- 4. Why does the Child Protective Services Background Clearance form request information on race, sex and birthdate for my children?**
  - a. Information on race, sex and birthdate are used to complete an accurate cross-reference search of the database. If you have questions regarding this matter you may contact Patricia Walker at 410-767-8821.
  
- 5. Can I refuse to answer questions on the form?**
  - a. No. All questions on the form must be completed or the form will not be processed.

**6. What if I don't have results back from Child Protective Services by the time camp starts?**

- a. The Personnel Administrator has the ability to log into myDHR and track the progress of their staff's applications. As long as the camp can document that all staff have at least initiated the process, we will take it as good faith that the results will be forthcoming.

**7. How often does an employee have to complete this process?**

- a. Each employee is only required to complete this process once as long as the camp personnel administrator maintains the results of the Child Protective Services Background Clearance on file.

**8. Do employees from out-of-state or another country need to complete the Child Protective Services Background Clearance form?**

- a. Yes. All employees must complete this form in order to work at a youth camp in Maryland, also see question 13.

**9. Are volunteers required to complete the Child Protective Services Background Clearance form?**

- a. No. Volunteers are not required to complete the Child Protective Services Background Clearance process. However, the camp personnel administrator may require volunteers to complete the process if they wish. The MDH recommends that volunteers complete the same background clearance process as employees since volunteers will have access to children.

**10. How do you create an account in myDHR?**

- a. Go to the following website:  
<https://mydhrbenefits.dhr.state.md.us/dashboardclient/#/home>
- b. Follow the instructions contained in the training slides for "Creating a myDHR Account" located on the "Most Requested Forms and Documents" page of our website.

**11. How does an employee fill out the Child Protective Services Background Clearance?**

- a. The employee should create an account by following the instructions in question 10.
- b. The employee should then complete, save, and print the Child Protective Services Background Clearance form using myDHR. The instructions for doing so are in the training slides for "Employees" located on the "Most Requested Forms and Documents" page of our website.

**12. How is a notarized Child Protective Services Background Clearance submitted to DHR for processing?**

- a. The employee turns in the completed and notarized form to the personnel administrator. The personnel administrator scans or takes a picture of all the pages of the form and then uploads those to the camp employees file within myDHR. Once these documents are upload the personnel administrator will complete the process and submit the application to DHR through the online portal. For specific information on how to complete this process please see the training slides for "Personnel Administrator" on the "Most Requested Forms and Documents" page of our website.

**13. What do I do if information is found in the Child Protective Services database?**

- a. The camp personnel administrator must assess the suitability for employment of the individual based on the criteria listed in COMAR 10.16.06.21F, which says:

"F. If, as reported on or after October 1, 2005, an individual has been identified as responsible for child abuse or neglect or received a conviction, a probation before judgment disposition, a not criminally responsible disposition, or a pending charge for the commission or attempted commission of a crime or offense that is not included in §E of this regulation, the operator:

- (1) Shall assess, on the basis of the following factors, the individual's suitability for employment:
  - (a) The job position at the camp for which the individual is applying or for which the individual is currently employed;
  - (b) The nature and seriousness of the incident, crime, or offense;
  - (c) The period of time that has elapsed since the incident, crime, or offense occurred;
  - (d) The age of the individual at the time the incident, crime, or offense occurred;
  - (e) The individual's probation or parole status, if applicable; and
  - (f) Any other information the camp considers pertinent; and
- (2) Depending on the results of the assessment, shall permit or prohibit employment of the individual."

**14. Can a person who is found unsuitable to be employed at the camp volunteer at the camp?**

- a. No, according to COMAR 10.16.06.21, once the personnel administrator determines that the person cannot be employed to work at camp because of the criminal or Child Protective Services results the person cannot then volunteer at camp.



# **EMERGENCY PROCEDURES**





Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Emergency Plan

Purpose

The purpose of a written emergency plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while at camp.

Training

Staff and volunteers must receive training in the emergency plan. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's emergency procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the emergency procedures.

Availability

A copy of the emergency plan must be available to the camp staff. The emergency plan must be on file in the headquarters or office of the camp.

- Where are copies of the written emergency plan kept?
- Do staff/volunteers receive a copy?

Writing Emergency Procedures:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. How do you monitor for severe weather?
2. When severe weather or other emergencies happen where do campers go to be safe?
3. How would campers and staff members evacuate the camp? (i.e. buses or cars)
4. Where would everyone go?
5. How do you account for all campers? (i.e. daily roster for whole camp, daily roster for each group, buddy system)
6. What are the procedures your staff members follow for locating a missing camper?
7. For each group of campers, the operator must have a minimum of two staff present. At least one staff member must be an adult. In the event of an emergency, who remains with an injured camper and who summons emergency assistance?
8. Where is a phone that can be used to dial 911 located?

9. Do senior staff members have cell phones or radios?
10. Who is responsible for calling 911?
11. How do you contact emergency services if the telephone is not working?
12. What is available for transporting campers and staff members in an emergency?
13. How would you notify parents of what is happening at camp regarding an emergency?
14. How does the camp receive emergency communication?
15. Where would parents pick up the campers if camp needed to be evacuated?
16. When are drills in the emergency procedures practiced with campers? Drills are required at the beginning of each session or anytime new campers are added.
17. Do you have a form to document the date, time, and outcome of each practice drill?

**TRIP  
AND  
TRANSPORTATION**



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Trip Safety Plan

Purpose

The purpose of a written trip safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while on a trip.

Training

Staff and volunteers must receive training in the trip safety plan. Training must include an opportunity to discuss the procedures and ask questions.

- Describe the training: what/where/when. Document that each staff/volunteer was trained not more than 30 days before camp.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's trip safety plan.

Availability

A copy of the trip safety plan must be available to the camp staff. The trip safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the written trip safety plan kept?
- Do staff/volunteers receive a copy?

Writing Trip Safety Plan:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. What are the potential health and safety risks for each trip?
2. How are the potential health and safety risks for each trip addressed?
3. What are the qualifications of the camp staff members for each trip?
4. What are the responsibilities of the camp staff members for each trip?
5. How are parents or guardians, campers, staff members and volunteers informed about a trip before campers participate in the trip?
6. How is written authorization from the camper's parent or guardian obtained before the camper participates in the trip?
7. What are the participation eligibility requirements for each trip?
8. What are the supervision requirements for each trip? Include staff to camper ratios (1 adult for 10 campers or a fraction of 10 campers).

9. What are the safety rules, standards, and practices for each trip?
10. Is there any equipment that will be used during a trip? If so, explain what it is, how it is to be maintained, and where it is to be stored.
11. How, when, and where are campers', staff members', and volunteers' health and emergency information maintained during a trip?
12. What form of emergency communication is available on a trip?
13. Who is the designated contact person on a trip?
14. How is attendance taken on a trip?
15. Who is the director or director's designee present on a trip?
16. Who has CPR and First Aid certifications? (At least 1 adult)
17. How will the camp contact person maintain the following:
  - A roster of participants?
  - Departure and return times?
  - Attendance during the:
    - Departure?
    - Activity?
    - Return?
  - An itinerary?
  - The route taken?
  - Inclement weather plans?
18. How will the camp operator ensure that:
  - A camper is instructed in the trip safety plan and use of any protective equipment?
  - A camper, staff member, or volunteer is provided with and uses safety equipment suitable to the trip?
  - The trip is conducted according to the safety plan?

Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Transportation Safety Plan

Purpose

The purpose of a written transportation safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while being transported.

Training

Staff and volunteers must receive training in the transportation safety plan. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's transportation safety plan.

- Describe the training: what/where/when.
- Document that each staff/volunteer was trained not more than 30 days before camp and knows the transportation safety plan.

Availability

A copy of the transportation safety plan must be available to the camp staff. The transportation safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the written transportation safety plan kept?
- Do staff/volunteers receive a copy?

Writing Transportation Safety Plan:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. Is transportation provided according to applicable State laws?
2. What are the transportation safety rules, standards and practices?
3. What are the supervision requirements during transportation? Include staff member to camper ratio.
4. What are the emergency transportation services should the need arise?
5. What are the severe weather procedures while being transported?
6. What safety equipment is provided and used? (i.e. car seats for younger children, seat belts)
7. Is the driver an adult?
8. Is the driver licensed according to applicable State law?
9. The number of occupants in the vehicle may not exceed the vehicle manufacturer's seating capacity. How will the camp operator ensure that this will be followed?

10. How will camp obtain written authorization from a camper's parent or guardian for the camper to be transported?
11. How is vehicular traffic controlled on the campsite?
12. How will the camp operator ensure that staff members and volunteers understand that campers **are not to be transported**:
  - In non-passenger vehicles,
  - An individual's car without obtaining written authorization from the camper's parent or guardian and the owner of the vehicle?

If camp provides transportation to camp, from camp or to and from camp include the answers to the following questions in your transportation safety plan:

13. Is the director available for consultation during transportation hours?
14. How will the following written information be provided to the camper's parent or guardian:
  - Camper's pick-up time and designated pick-up location?
  - Camper's drop-off time and designated drop-off location?
  - Camp's pick-up and drop-off safety procedures?
  - Camp's policy concerning the camp's responsibility for supervising a camper when the camper is picked up, dropped off, and transported?
15. How will camp obtain a written agreement from the camper's parent or guardian concerning the parent's or guardian's responsibility for supervising a camper before the camper is picked up and after the camper is dropped off?
16. When there are 10 or more campers in a vehicle, how will camp ensure that in addition to the driver that there is another assistant counselor or adult on duty and supervising the campers? Include staff member to camper ratio?



# **SPECIALIZED ACTIVITIES**



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Swim Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running swimming programs. The Specialized Activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the swim safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the swim safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the swim safety plan must be available to the camp staff. The swim safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing a Swim Safety Plan and Procedures:

Provide the following:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from CIT to Director. For trips and when activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.

Describe your procedures or the actions you want staff to take for each question or item:

4. Prior to swimming, how are parents, staff, and campers notified of the activity?
5. How does the camp obtain written authorization from the child's parent for the camper to participate in swimming?

6. What are the minimum requirements for campers to participate? (ie. age, skills, etc.)
7. What is your minimum staff to camper ratio? (State requirement is 1 staff to 10 campers; yours may be stricter.)
8. Describe all safety rules, standards, and practices.
9. Describe the equipment to be used, your maintenance schedule and storage procedures for the equipment.
10. Describe your safety procedures and the proper use of the equipment.
11. Describe how campers are instructed in safety procedures and the use of any protective equipment.
12. When activity is not on camp premises:
  - a. Where and how is health and emergency information for campers, staff members, and volunteers kept?
  - b. How does the group participating in swimming communicate to emergency services (911), parents and main camp office in an emergency?
  - c. Who is the contact person for the swimming activity? What is their phone number?
  - d. Describe procedures (who/how/when) for taking attendance for the swimming.
13. How do you evaluate a camper's swimming ability before a camper participates in swimming?
  - a. Describe the swim test. This is not the facility's swim test to use the deep end of the pool, you must have a test for all swimmers. Keep a list of campers and swim ability. Do not rely on the facility to keep track of this information.
14. How do you identify which campers may use which areas of the pool once the swim test is completed? (Examples include plastic colored wristband, colored swim caps, etc)
  - a. Campers with weak swim skills must stay where the water is not deeper than their chest.
  - b. Allow only the campers with strong swim skills to use the area of the pool that is deeper than their chest.

15. How do you quickly account for all campers during the swimming activity?
16. What is your minimum lifeguard to swimmer ratio? (State requirements are 1 lifeguard on duty per 50 swimmers) Note: Lifeguard certification must be appropriate to the swimming site. Certification for pool lifeguards is different from certification for natural bathing area lifeguards. Be sure your staff have the appropriate certification for your swimming site.
17. What is your minimum watcher to swimmer ratio? (State requirements are 1 watcher on duty per 25 swimmers)
18. Using a diagram of the pool or natural bathing area, describe where the lifeguards and watchers are positioned.
19. Describe who on the camp staff will attend to other camper needs while at the swimming activity, such as, taking campers for bathroom breaks, supervising campers who are not in the water, etc. Watchers CANNOT have any other responsibilities while on duty as the 'watcher'.



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Watercraft Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running watercraft programs. The Specialized Activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the watercraft safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the watercraft safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the watercraft safety plan must be available to the camp staff. The watercraft safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing a Watercraft Safety Plan and Procedures:

Provide the following:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from CIT to Director. For trips and when activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.

Describe your procedures or the actions you want staff to take for each question or item:

4. Prior to the watercraft, how are parents, staff, and campers notified of the activity?

5. How does the camp obtain written authorization from the child's parent for the camper to participate in the watercraft activity?
6. What are the minimum requirements for campers to participate? (ie. age, skills, etc.)
7. What is your minimum staff to camper ratio? (State requirement is 1 staff to 10 campers; yours may be stricter.)
8. Describe all safety rules, standards, and practices.
9. Describe the equipment to be used, your maintenance schedule and storage procedures for the equipment.
10. Describe your safety procedures and the proper use of the equipment.
11. Describe how campers are instructed in safety procedures and the use of any protective equipment.
12. When activity is not on camp premises:
  - a. Where and how is health and emergency information for campers, staff members, and volunteers kept?
  - b. How does the group participating in the watercraft activity communicate to emergency services (911), parents and main camp office in an emergency?
  - c. Who is the contact person for the watercraft activity? What is their phone number?
  - d. Describe procedures (who/how/when) for taking attendance for the watercraft.
13. How do you evaluate a camper's swimming ability before a camper participates in the watercraft activity?
  - a. Describe the watercraft test. This is not the facility's swim test to use the deep end of the pool, you must have a test for all participants. Keep a list of campers and swimming ability. Do not rely on the facility to keep track of this information.
14. How do you assign campers to appropriate areas, equipment, and activities once the swim test is completed?
15. Describe your maintenance procedures for watercraft activity equipment to ensure it is in good working condition.



16. How do you quickly account for all campers during the watercraft activity?
17. Describe the type of watercraft used in each watercraft activity, the number and age of the occupants and the types of U.S. Coast Guard approved personal flotation devices used.
18. For water skiing, state that all water skiers must wear a personal flotation device approved by the U.S. Coast Guard for that particular activity.
19. For a watercraft towing a water skier, state that the watercraft will have an observer on board in addition to the driver.
20. State that all occupants of a watercraft wear a U.S. Coast Guard approved personal flotation device.
21. Describe the training provided to individuals using a watercraft related to:
  - a. Boarding;
  - b. Debarking;
  - c. Safety procedures for the craft.
22. Except for river trips, state that the instructor is within sight and hearing of the watercraft activity.
23. For river trips, describe the instructor's supervision if the instructor is not within sight and hearing of the watercraft activity.
24. How many individuals holding certification in first aid and CPR are present at each watercraft activity? (The minimum State requirement is 1 individual for each watercraft activity.)
25. How many individuals holding either lifeguard or water rescue certification appropriate for the watercraft site are present at each watercraft activity? (The minimum State requirement is 1 lifeguard or water rescuer for each watercraft activity.)
26. Using a diagram of the site, describe where the instructor, lifeguard(s)/water safety rescuer(s) and staff members are positioned.



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Archery Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running archery programs. The Specialized Activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the archery safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the archery safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the archery safety plan must be available to the camp staff. The archery safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing an Archery Safety Plan and Procedures:

Provide the following information:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from Counselor in Training, (CIT) to Director. When activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.
4. How is the target range located, so as to protect campers from wandering into the field of fire while engaged in other camp activities?
5. How will the direction of fire be oriented to minimize a shooter being blinded by the sun?
6. How will signs be posted to prevent the accidental entry into the field of fire?
7. How will shooters be stationed relative to each other?

8. Is there an established ready line at least 10 feet to the rear of the firing line?
9. Does the range area have at least 50 yards of clearance, or an archery net behind each target?
10. When different archer-to-target distances are required for a group that is shooting:
  - (a) Will one common shooting line be used?
  - (b) Are the targets set at a distance from the shooting line that is appropriate for the skill level of the camper?
11. Is there a common shooting line with a ready line marked behind it?
12. How will you ensure that only archers ready to shoot are on the firing line, and anyone waiting to shoot remains, behind the ready line?
13. How will you ensure that an individual stays behind the firing line at all times, except when ordered by the instructor to retrieve a target or arrow?
14. How are campers to be instructed before taking part in the activity?
15. How will the equipment be controlled, maintained and stored when not in use?
16. What protective equipment will be provided for safety?

Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Marksmanship Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running marksmanship programs. The Specialized Activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the marksmanship safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the marksmanship safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the marksmanship safety plan must be available to the camp staff. The marksmanship safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing a Marksmanship Safety Plan and Procedures:

Provide the following:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from Counselor in Training, (CIT) to Director. When activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.
4. How is the target range located, so as to protect campers from wandering into the field of fire while engaged in other camp activities?
5. How will the direction of fire be oriented to minimize a shooter being blinded by the sun?
6. How will signs be posted to prevent the accidental entry into the field of fire?

7. How will shooters be stationed relative to each other?
8. Is there an established ready line at least 10 feet to the rear of the firing line?
9. Is the range free of any objects that may cause a bounce back or ricochet?
10. Does the range have a backstop or is there visibility greater than 3,000 feet?
11. If there is a backstop:
  - (a) Is it not less than 30 feet?
  - (b) Is it clear of brush or other objects that may obstruct visibility for at least 100 yards?
  - (c) Have cuts been taken out of the slope directly behind the targets to provide a perpendicular surface to prevent ricochets?
  - (d) Have all rocks, glass, and metal been removed from the cuts to prevent ricochets?
  - (e) Have any non-removable objects been covered with at least 6 inches of soil and been sodded or seeded to prevent ricochets?
  - (f) If a wood crib is to be used as a backstop, has it been filled with dry earth or sand; and is at least 10 feet high, by 30 inches thick, and is at least 6 feet behind the targets?
12. For air guns:
  - (a) Does the backstop comply with all other riflery requirements, as well as is covered with a soft material to prevent ricochets?
  - (b) What are the walls or side berms covered with to prevent ricochets and contain pellets?
  - (c) How are campers to be instructed before taking part in the activity?
13. How will the equipment be controlled, maintained and stored when not in use?
14. What protective equipment will be provided for safety?

Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Horseback Riding Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running horseback riding programs. The Specialized Activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the horseback riding safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the horseback riding safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the horseback riding safety plan must be available to the camp staff. The horseback riding safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing a Horseback Riding Safety Plan:

Provide the following:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from Counselor in Training, (CIT) to Director. When activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.
4. How does the instructor determine a camper's riding experience before assigning a horse and deciding where they may ride?
5. How does the instructor ensure that appropriate headgear is worn by all riders?
6. How does an instructor ensure that shoes with heels or closed stirrups are used?

7. How does the instructor ensure that horses are healthy and the stable meets COMAR 15.16.01?
8. Provide detail on how a director is either at camp or on site where campers are riding.
9. Provide detail on how an instructor will be present at each riding activity.
10. Determine how an adult staff member, adult volunteer, counselor, or assistant counselor is on duty and supervising the campers, (one for each ten riders) for each riding activity or trail excursion.



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Other Specialized Activity Safety Plan

Purpose

The purpose of a written safety plan is to inform camp staff and volunteers what actions to follow to ensure each camper's safety while running the specialized activity. The specialized activity must be conducted according to the safety plan.

Training

Staff and volunteers must receive training in the specialized activity safety plan. Training must include an opportunity to discuss the plan and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the specialized activity safety plan procedures.

- Describe the training: what/where/when. Document that each staff/volunteer was trained before camp and knows the safety plan.

Availability

A copy of the specialized activity safety plan must be available to the camp staff. The specialized activity safety plan must be on file in the headquarters or office of the camp.

- Where are copies of the safety plan kept?
- Do staff/volunteers receive a copy?

Writing an Other Specialized Activity Safety Plan and Procedures:

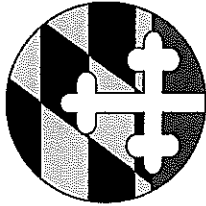
Provide the following:

1. What are the health and safety risks of the activity?
2. What minimum staff qualifications are required for the activity?
3. Describe staff responsibilities for each staff position, from Counselor in Training, (CIT) to Director. When activity is not on camp premises, a director (an individual who is 21 years old or older and has at least 24 weeks of supervisory experience) must accompany the activity.

Describe your procedures or the actions you want staff to take for each question or item:

4. Prior to the camper participating in the specialized activity, how are parents, staff, and campers notified of the activity?
5. How does the camp obtain written authorization from the child's parent for the camper to participate in the specialized activity?

6. What are the minimum requirements for campers to participate? (ie. age, skills, etc.)
7. What is your minimum staff to camper ratio? (State requirement is 1 staff to 10 campers; yours may be stricter.)
8. Describe all safety rules, standards, and practices.
9. Describe the equipment to be used, your maintenance schedule and storage procedures for the equipment.
10. Describe your safety procedures and the proper use of the equipment.
11. Describe how campers are instructed in safety procedures and the use of any protective equipment.
12. When activity is not on camp premises:
  - a. Where and how is health and emergency information for campers, staff members, and volunteers kept?
  - b. How does the group participating in the specialized activity communicate to emergency services (911), parents and main camp office in an emergency?
  - c. Who is the contact person for the specialized activity? What is their phone number?
  - d. Describe procedures (who/how/when) for taking attendance for the specialized activity.
13. Describe the qualification of the instructor for the specialized activity. (Instructor must be present at the specialized activity.)



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

## INTERPRETIVE MEMORANDUM

**DATE:** April 17, 2017

**TO:** Maryland Youth Camp Operators, Center for Healthy Homes and Community Services  
Staff and Summer Inspectors

**FROM:** Joseph T. McKenzie, III, LEHS, REHS/RS, MPH, Chief  
Center for Healthy Homes and Community Services

**RE:** COMAR 10.16.06.47F(8), Water Safety Rescuer

This memo summarizes the Department's review of our findings regarding materials provided from both the US Sailing Association and the American Canoeing Association on training for watercraft camp personnel and water rescue around the potential equivalence of this training to meet the training requirements specified in COMAR 10.16.06.47F(8): "[One] lifeguard or water safety rescuer who has lifeguard or rescuer certification appropriate for the watercraft site". After the review, we agree that the training content and materials do address the necessary safety issues. Therefore, the Department agrees that staff members who have successfully completed the following curriculum would meet the criteria in COMAR 10.16.06.47F(8):

1. US Sailing – Small Boat Level 1 Instructor
2. American Canoeing Association – Level 3: River Canoeing Instructor
3. American Canoeing Association – Level 3: River Kayaking Instructor

Camps who can demonstrate that their staff members have successfully completed the appropriate training for the watercraft activity will be considered to be in compliance with this provision of the youth camps regulations, so long as they meet the following requirements:

1. At the time of inspection the camp provides appropriate documentation of successful completion of the appropriate training for the watercraft activity for each staff member who falls under the provision;
2. The number of staff so trained and designated is at least as great as the number specified in COMAR;
3. The camp is using the most current version of the applicable training curriculum; and
4. If the curriculum changes, US Sailing or the American Canoeing Association (or another entity representing watercraft camps) notifies the Department to permit a review of the modified curriculum.

This finding does not address other curricula or training materials that may be in use by other camps participating in watercraft activities. The Department reserves the right to review this decision in the future, based on changes in regulation, training materials, and the course content, or other circumstances.



# **SUPERVISION**



**Supervision of Campers During Routine Activities Chart  
COMAR 10.16.06.54**

Number of campers in group	Required Number of Adults and Assistant Counselors	
	Adult(s)	Assistant Counselor(s) or Adult(s)
3 ½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2
	or	
	2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2
	or	
	2	0
31 to 40	2	2
	or	
	3	0

**Instructions:** Determine the age of the youngest camper within the group, find that age on the chart. Then determine the number children in the group and use those supervision ratios for the group. Adult means an individual 18 years old or older or an individual 17 years old who has graduated from high school. Assistant Counselor means an individual who is 16 years old or older or an individual who has successfully complete the tenth grade.

**Example:** If my group has campers that are 4 years old to 7 years old, I would use the blue section for 3 ½ to 5 years old. Since I have 10 campers in my group I determine that I need 1 adult plus another adult or assistant counselor to meet the routine supervision ratios required by this regulation.





**CHILD ABUSE  
PREVENTION AND  
REPORTING**



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Child Abuse Prevention and Reporting Program

Purpose

The purpose of a written child abuse prevention and reporting program is to inform camp staff and volunteers what actions to follow to ensure camper's safety while at camp.

Training

Staff and volunteers must receive training in the child abuse prevention and reporting program. Training must include an opportunity to discuss the procedures and ask questions.

Knowledge and Conduct

Staff and volunteers must know and follow the camp's child abuse prevention and reporting program.

- Describe the training: what/where/when. Document that each staff member/volunteer was trained before camp and knows the child abuse prevention and reporting program.

Availability

A copy of the child abuse prevention and reporting program must be available to the camp staff. The child abuse prevention and reporting program must be on file in the headquarters or office of the camp.

- Where are copies of the written child abuse prevention and reporting program kept?
- Do staff members/volunteers receive a copy?

Writing Child Abuse Prevention and Reporting Program:

Answer each question by describing your procedures or the actions you want your staff members to take:

1. When, where, and how are staff members and volunteers educated on the child abuse?
2. What are the internal and external steps to reporting suspected child abuse?
3. How are staff members and volunteers screened prior to working at camp? (i.e. required background checks, CPS clearances, interviews, reference checks, etc.)
4. How do staff members and supervisors reinforce the camp's policies and procedures related to child abuse prevention during camp operation? (i.e. camp's code of conduct, training and monitoring, etc.)
5. Who evaluates the facilities and grounds related to child abuse prevention?
6. What areas of the facility or grounds are high risk areas?
7. What precautions are taken to limit exposure to or time in high risk areas?

8. What is the camp's staffing and supervision structure? (i.e. ratios of staff to campers, procedures for limiting one on one interactions, open door policy, etc.)
9. How are staff members, volunteers and campers educated about the camp's policy on appropriate touching?
10. What is camp's policy for dealing with inappropriate behaviors by:
  - o Staff members/volunteers?
  - o Parents?
  - o Campers?
11. Who will communicate with:
  - o Staff members and volunteers?
  - o Campers and parents?
  - o The Department of Health and Mental Hygiene?
  - o The media?
12. How will staff members/volunteers support an alleged victim?
13. How will staff members/volunteers interact with an alleged perpetrator?

*While these questions form the minimum requirements of the regulations, the Center for Healthy Homes and Community Services has also made available on its website a self-assessment tool. Please consider using this tool when evaluating your camp with regards to child abuse prevention and reporting.*

**Maryland Department of Health and Mental Hygiene**  
**Center for Healthy Homes and Community Services**

**Child Abuse Prevention and Reporting**  
**Self-Assessment Tool**

This self-assessment tool is designed to assist youth camp operators in developing a child abuse prevention and reporting plan. The self-assessment tool will walk you through the various questions and strategies needed to create a safer space for your campers. The goal is to increase your camp's strengths while decreasing the risks that are inherent within a youth camp.

If you find that you have answered "yes" to all of the questions in a section, congratulations. Celebrate what you have already accomplished as well as the protections you have already put into place. If you answered "no" to some questions it does not mean that you should immediately develop a new policy or procedure. Rather, this process will help you look at your camp's mission, programs, and resources and decide what makes the most sense for your camp today. It will also help you identify your next steps as you plan for what may be possible for the next 3-5 years.

After you have completed the survey, review what you have in place (your protective factors) and then decide as a camp, what strategies you may want to consider as you strengthen your camp. Remember, do not try to create more policies or procedures than you have the resources to realistically put into place. It is better to start small and then add along the way as resources or compelling reasons emerge.

Finally, as you go through each question, you do not have to do this alone. You may want to create a review team or ask a few staff members to help in different areas. If you have any questions about the process, please do not hesitate to contact the Center for Healthy Homes and Community Services at 410-767-8417.

Camp Name:

**EDUCATE**

**For Employees**

#	Question	Yes	No	Unsure	N/A
1	Are child abuse prevention policies included in the orientation of new employees?				
2	Do you train all employees about child abuse and how to recognize the indicators of abuse?				
3	Are employees trained in how to respond to an adult's inappropriate behaviors toward children?				
4	Are employees trained in how to respond to inappropriate behaviors between children and between adolescents?				
5	Are employees trained on the legal requirements for reporting and responding to allegations of child abuse?				

**For Volunteers**

6	Are child abuse prevention policies included in the orientation of new volunteers?				
7	Do you train all volunteers about child abuse and how to recognize the indicators of abuse?				
8	Are volunteers trained in how to respond to an adult's inappropriate behaviors towards children?				
9	Are volunteers trained in how to respond to inappropriate behaviors between children and between adolescents?				
10	Are volunteers trained on the legal requirements for reporting and responding to allegations of child abuse?				

**For All**

11	Do you provide access to free materials and online courses to educate program staff, volunteers and all agency employees about child abuse, especially if they are unable to attend orientation or training?				
----	--	--	--	--	--

**RESPONDING (REPORTING)**

#	Question	Yes	No	Unsure	N/A
12	Is your organization familiar with the laws pertaining to child abuse (e.g., mandated reporting laws, process of reporting, etc.)?				
13	Does your organization have a person or committee responsible for confronting any sexual or other misconduct by staff?				
14	Does your organization have a person or committee responsible for reporting allegations of child abuse?				
15	Is there a clear policy and protocol in place for how to report an allegation of child abuse?				
16	Has your organization contacted the county child protection services to confirm the correct reporting procedures?				
17	Do you have specific insurance requirements related to child abuse that you need to incorporate into your policies and procedures?				

**PREPARE (SCREEN)**

Do you have a basic application and screening process that includes:

18	A written application?				
19	Face to face interviews?				
20	At least three professional (or personal) reference checks?				
21	An internet search?				
22	A criminal background check?				
23	A sex offender registry check?				
24	A child protective services background clearance check?				

#	Question	Yes	No	Unsure	N/A
25	Do you ask any questions during the interview process that specifically addresses child abuse prevention?				
<b>REINFORCE</b>					
26	Do you review your policies to ensure that they are up to date annually?				
27	Is there a regular (e.g., annual) review with staff members of any change in child abuse prevention policies (e.g., in a staff meeting or by a formal training) to ensure that employees are aware of these changes? Review for staff members even if no change?				
28	Does formal supervision address appropriate and inappropriate behaviors with children and between children (e.g. boundaries, touching, etc.)?				
29	Does informal supervision exist within the organization (e.g., time for supervisor to drop in on activities)?				
30	If an issue has been identified and behavior is being monitored, has documentation also occurred?				
<b>FACILITY AND GROUNDS</b>					
<b>Visibility</b>					
31	Are there windows on all doors or an open door policy when meeting with children or teens?				
32	Is there adequate lighting in all rooms?				
33	Are isolated areas off limits for youth?				
34	Are all isolated areas closed, locked and secured?				
35	In larger facilities, are there operating cameras in less frequented areas?				



<b>Building Usage</b>					
#	Question	Yes	No	Unsure	N/A
36	Is there a clearly defined building usage strategy to minimize unsupervised access to children and youth in the program?				
37	Are there clear physical boundaries of the organization's space (e.g., when the organization is responsible and when the caregivers are responsible)?				
38	Is there clear signage to ensure that people know where to go for various activities?				
39	Are programs that may present a threat to children and youth clearly separated from the children's space? (e.g., in a multi-disciplinary agency, are the services for children kept in a different part of the building than the space for homeless men and women)?				
<b>Administration</b>					
40	Is there an emergency phone accessible to staff, children and youth?				
41	Is access to children and youth addresses and contact information closely monitored and not released to any unauthorized individuals?				
<b>SAFETY POLICIES</b>					
<b>Entry and Exits</b>					
42	Do procedures exist for welcoming and departing children and youth?				
43	Do procedures ensure that children and youth are monitored during transitions from one activity to another?				
44	Do procedures exist for entry and exiting of parents, guardians, and guest?				
45	Do you have a clear policy for parents to drop in to observe or participate in activities?				
46	Are all entrances and exits clearly supervised (if not locked at all times)?				

**Offsite Trips**

#	Question	Yes	No	Unsure	N/A
47	Are there guidelines for obtaining caregiver permission for offsite trips?				
48	Are there guidelines for transporting children and youth for offsite trips?				
49	Are there guidelines for overnight stays during offsite trips?				

**Supervision**

50	Are there guidelines for certain high risk activities (e.g., toileting for young children)?				
51	If yes, are the guidelines age appropriate?				
52	Is there a designated observer (someone who ensures that the policies and procedures of the organization are carried out) to ensure all children are adequately supervised?				
53	Are adults allowed to have one-on-one contact with children (e.g., a mentor relationship, big brother, etc.)?				
54	If yes, are there regular contacts, group supervision, etc. to monitor this one-on-one contact?				
55	Are there set ratios of employee/volunteer to children/youth?				
56	Do you have process to ensure that these protocols are followed?				
57	Is teen access to children limited or very well supervised (e.g., teens are never put in the position of sole leadership of younger children)?				

**SAFETY POLICIES**

58	Is there a clear procedure or guideline for responding to inappropriate behaviors toward children and youth by staff members?				
59	Is there a clear procedure or guideline for responding to inappropriate behaviors between children and youth?				

#	Question	Yes	No	Unsure	N/A
60	Are there clear guidelines for appropriate touch in the organization?				
<b>COMMUNICATIONS AND HEALING</b>					
61	Is one person assigned to talk with the media, staff members, youth or families involved if/when an allegation is made against an employee, volunteer, or child/youth participating in the organizational activities?				
62	Is there a person (could be same person) assigned to talk with the media, staff members, youth or families involved when a case of child abuse is uncovered in a participant's family?				
63	Is there a policy or protocol on how to support the alleged victim once an allegation has been made?				
64	Is there a policy or protocol about how to deal appropriately with the alleged perpetrator (adult, teen, or child) once an allegation of child abuse has been made?				

*This "Self-Assessment Tool" was adapted from a tool developed in 2008 by Enough Abuse Campaign Consultant Joan Tabachnick and the Massachusetts Child Sexual Abuse Prevention Partnership's Youth-Serving Organizations' Work Group.*



# Department of Human Resources

## Child Protective Services

<http://www.dhr.state.md.us/cps>

### What is Child Abuse and Neglect?

CODE OF MARYLAND REGULATIONS (COMAR) defines child abuse and child neglect as:

- Physical injury *not necessarily visible* of a child under circumstances that indicate that a child's health or welfare is harmed or at substantial risk of being harmed.
- The failure to give proper care and attention to a child including the leaving a child unattended where the child's health or welfare is harmed or a child is placed in substantial risk of harm.
- An act or acts involving sexual molestation or exploitation whether physical injuries are sustained or not.
- Identifiable and substantial impairment of a child's mental or psychological ability to function.
- Finding credible evidence that has not been satisfactorily refuted that physical abuse, neglect or sexual abuse occurred.

**Department of Human Resources**  
**General Information: 1-800-332-6347**  
**TTY: 1-800-332-6347**  
Numero del telefono directo: 1-800-732-7850  
**Social Services Administration**  
(410) 767-7112

### Local Departments of Social Services Child Protective Services for the State of Maryland

County	Phone Number & Address
Allegany County	Tel: (301) 784-7122, After hours: (301) 759-0362 FAX: (301) 784-7244 Address: One Frederick Street, Cumberland, Maryland 21502
Anne Arundel County	Tel: (410) 421-8400 FAX: (410) 508-2041 Address: 7500 Ritchie Hywy, Glen Burnie, Maryland 21061-1787
Baltimore City	Tel: (410) 361-2235 (24 hours) FAX: (443) 423-7003 or 7002, After 3:30-hours (443) 423-5950 Address: 1900 N. Howard Street, Baltimore, Maryland 21218
Baltimore County	Tel: (410) 853-3000 (Option 1) After hours: (410) 583-9398 FAX: (410) 853-3698 Address: Drumcastle Government Center, 6401 York Road, Baltimore, Maryland 21212
Calvert County	Tel: 1-443-550-6900, After hours: (Toll Free: 1-800-787-9428) FAX: (410) 286-7429 Address: 200 Duke Street, Prince Frederick, Maryland 20678
Caroline County	Tel: (410) 819-4500, After hours: (410) 479-2515 Sheriff's Office. FAX: (410) 819-4501 Address: 207 South Third Street, Denton, Maryland 21629
Carroll County	Tel: (410) 386-3434 (24 Hours) FAX: (410) 386-3477 Address: 1232 Tech Drive, Westminster, Maryland 21157
Cecil County	Tel: (410) 996-0100 (Option 3), After hours: (410) 996-5350 FAX: (410) 996-0228 Address: 170 East Main Street, Elkton, Maryland 21922-1160

County	Phone Number & Address
<b>Charles County</b>	Tel: (301) 392-6739, After hours: (301) 932-2222 FAX: (301) 934-2662 Address: P.O. Box 1010, 200 Kent Avenue, LaPlata, Maryland 20646
<b>Dorchester County</b>	Tel: (410) 901-4100, After hours: (410) 221-3246 FAX: (410) 901-1060 Address: P.O. Box 217, 627 Race Street, Cambridge, Maryland 21613
<b>Frederick County</b>	Tel: (301) 600-2464, After hours: (301) 600-2100 Police Dept. FAX: (301) 600-2639 Address: 100 East All Saints Street, Frederick, Maryland 21701
<b>Garrett County</b>	Tel: (301) 533-3005, After hours: (301) 334-1930 Sheriff's Office. FAX: (301) 334-5413 Address: 12578 Garrett Highway, Oakland, Maryland 21550
<b>Harford County</b>	Tel: (410) 836-4713, After hours: (410) 838-6600 Sheriff's Office. FAX: (410) 836-4945 Address: 2 South Bond Street, Bel Air, Maryland 21014
<b>Howard County</b>	Tel: (410) 872-4203, After hours: (410) 313-2929 Police Dept. FAX: (410) 872-4303 Address: 7121 Columbia Gateway Drive, Columbia, Maryland 21046
<b>Kent County</b>	Tel: (410) 810-7600, After hours: (410) 758-1101 State Police FAX: (410) 778-1497 Address: 350 High St, Chestertown, Maryland 21620
<b>Montgomery County</b>	Tel: (240) 777-4417 (24 hours) FAX: (240) 777-4258 Address: The Dept. of Health & Human Services, 1301 Piccard Drive Rockville, Maryland 20850
<b>Prince George's County</b>	Tel: (301) 909-2450, After hours: (301) 699-8605 FAX: (301) 909-2200 Address: 805 Brightseat Road, Landover, Maryland 20785
<b>Queen Anne's County</b>	Tel: (410) 758-8000 (all hours), After hours: (410) 758-0770 Sheriff's Office. FAX: (410) 758-8110 Address: 125 Comet Drive, Centreville, Maryland 21617
<b>St. Mary's County</b>	Tel: (240) 895-7016, After hours: (301) 475-8016 FAX: (240) 895-7099 Address: 23110 Leonard Hall Drive, Leonardtown, Maryland 20650
<b>Somerset County</b>	Tel: (410) 677-4200, After hours: (410) 651-9225 Sheriff's Office Centra, Emergency Services. FAX: (410) 677-4300 Address: P.O. Box 369, 30397 Mt. Vernon Road, Princess Anne, Maryland 21853
<b>Talbot County</b>	Tel: (41) 770-4848 (option#1), After hours: (410) 822-3101 MD State Police FAX: (410) 820-7067 Address: 301 Bay Street, Easton, Maryland 21601
<b>Washington County</b>	Tel: (240) 420-2222 (24 hours) FAX: (240) 420-2549 Address: 122 North Potomac Street, Hagerstown, Maryland 21741-1419
<b>Wicomico County</b>	Tel: (410) 713-3900 (option#1), After hours: (410) 548-4891 FAX: (410) 713-3910 Address: 201 Baptist Street, Salisbury, Maryland 21802-2298
<b>Worcester County</b>	Tel: (410) 677-6800, After hours: (410) 632-1111 (option#2) Sheriff's Office. FAX: (410) 677-6810 Address: 299 Commerce Street, Snow Hill, Maryland 21863

# **FACILITIES**





# LOCAL HEALTH APPROVAL

For Youth Camp locations that have an On-Site Well, On-Site Sewage Disposal, Portable Toilets, or Privies

Maryland Department of Health (MDH)  
 Center for Healthy Homes and Community Services (CHHCS)  
 6 St. Paul Street, Suite 1301  
 Baltimore, Maryland 21202-1608  
 (410) 767-8417 Fax (410) 333-8926  
 Toll Free 1-877-4MD-MDH ext. 8417

<b>CAMP OPERATOR</b>					
If your youth camp facility has an on-site water supply and/or sewage disposal system, annual approval from the local environmental health department is required. Complete the information in this section and forward the form, 90 days before the camp operates, to the appropriate local environmental health department on page 2.					
If your camp operates at a school (public or private) or a government owned building or park that is used by the public more than 170 days per year, use the Building Safety form, instead of this form.					
CAMP OPERATOR NAME			PHONE		FAX
CAMP NAME			DATES OF OPERATION		CAMP OCCUPANCY
MAILING ADDRESS			SITE ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP

**LOCAL HEALTH DEPARTMENT**  
 The operator is seeking a youth camp certificate or letter of compliance from the Maryland Department of Health, Center for Healthy Homes and Community Services for the above referenced camp. The water supply and/or sewage disposal system is on-site and requires approval from your Office. Complete the information below, sign, and return the form to the camp operator listed above.

**WATER SUPPLY**

> Indicate type of on-site water supply.  Individual water supply system.  
 Public transient noncommunity water supply system.  Public nontransient noncommunity water supply system.

> Indicate if the water supply is adequate, easily accessible to the campers, of a safe and sanitary quality and from an approved water supply system which is constructed, protected, operated and maintained in conformance with COMAR 26.04.01, 26.04.04 and applicable local subdivision ordinances.  
 APPROVED  DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action.  NOT APPLICABLE

Date of last sample(s) \_\_\_\_\_

Remarks: \_\_\_\_\_

SIGNATURE	TITLE	DATE	PHONE
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**SEWAGE DISPOSAL SYSTEM**

> Indicate if the on-site sewage disposal system is installed, operated, and maintained in compliance with COMAR 26.04.02.  APPROVED  DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action.  NOT APPLICABLE

System Capacity (# persons) \_\_\_\_\_

> Indicate if portable toilets are permitted.  YES # \_\_\_\_\_  NO  NOT APPLICABLE  
 If yes, is a maintenance agreement with an approved scavenger in place?  YES  NO

> Indicate if a privy is constructed and maintained so that it is fly-proof and rodent proof and conforms to COMAR 26.04.02 and Environment Article, Section 9-223(d)(1), Annotated Code of Maryland.  
 APPROVED  DISAPPROVED Please notify the Center for Consumer Health Services of the violation(s) and corrective action.  NOT APPLICABLE

Remarks: \_\_\_\_\_

SIGNATURE	TITLE	DATE	PHONE
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## LOCAL ENVIRONMENTAL HEALTH DEPARTMENTS

Allegheny County Health Dept.  
Environmental Health Division  
P.O. Box 1745  
Cumberland, Maryland 21501-1745  
Telephone (301) 759-5040  
Fax Number (301) 777-5583

Anne Arundel Co. Health Dept.  
Division of Environmental Health  
3 Harry S. Truman Parkway  
Annapolis, Maryland 21401  
Telephone (410) 222-7180  
Fax Number (410) 222-7678

Baltimore City Bureau of Environmental Health  
1001 E Fayette St  
Baltimore, Maryland 21202  
Telephone (410) 396-4424  
Fax Number (410) 396-5986

Baltimore County Environmental  
Protection & Resource Management  
111 W Chesapeake Ave, Ste 319  
Towson, Maryland 21204-4420  
Telephone (410) 887-3733  
Fax Number (410) 887-4804

Calvert County Health Department  
Environmental Health Division  
P.O. Box 980  
Prince Frederick, Maryland 20678  
Telephone (410) 535-3922  
Fax Number (410) 535-5252

Caroline County  
Division of Environmental Health  
403 S 7<sup>th</sup> Street- Room 248  
Denton, Maryland 21629  
Telephone (410) 479-8045  
Fax Number (410) 479-4082

Carroll County Health Department  
Bureau of Environmental Health  
290 S. Center St.  
Westminster, Maryland 21158  
Telephone (410) 876-1884  
Fax Number (410) 876-4430

Cecil County Health Department  
Environmental Health Services  
401 Bow Street  
Elkton, Maryland 21921-5515  
Telephone (410) 996-5160  
Fax Number (410) 996-5153

Charles County Health Department  
Environmental Health Services  
4545 Crain Highway  
White Plains, Maryland 20695  
Telephone (301) 609-6751  
Fax Number (301) 609-6684

Dorchester County Health Department  
Environmental Health Division  
3 Cedar Street  
Cambridge, Maryland 21613  
Telephone (410) 228-1167  
Fax Number (410) 901-8192

Frederick County Health Department  
Environmental Health Services  
350 Montevue Lane  
Frederick, Maryland 21702  
Telephone (301) 600-1719  
Fax Number (301) 600-3180

Garrett County Health Department  
Environmental Health Services  
1025 Memorial Drive  
Oakland, Maryland 21550  
Telephone (301) 334-7760  
Fax Number (301) 334-7769

Harford County Bureau of  
Environmental Health  
120 S. Hays Street Ste 200  
Bel Air, Maryland 21014-0191  
Telephone (410) 877-2300  
Fax Number (443) 643-0333

Howard County Health Department  
8930 Stanford Blvd  
Columbia, Maryland 21045  
Telephone (410) 313-1771  
Fax Number (410) 313-2648

Kent County Environmental Health  
125 S. Lynchburg St.  
Chestertown, Maryland 21620  
Telephone (410) 778-1361  
Fax Number (410) 778-7017

Montgomery County  
License and Regulatory Services  
255 Rockville Pike Suite 120  
Rockville, Maryland 20850  
Telephone (240) 777-3986  
Fax Number (240) 777-7765

Prince George's County Health  
Department/Environmental Health  
9201 Basil Court, Suite 318  
Largo, Maryland 20774  
Telephone (301) 883-7605  
Fax Number (301) 883-7601

Queen Anne's County Health Department  
Environmental Health Section  
206 North Commerce Street  
Centreville, Maryland 21617  
Telephone (410) 758-2281  
Fax Number (410) 758-6602

Somerset County Health Department  
7920 Crisfield Highway  
Westover, Maryland 21871  
Telephone (443) 523-1730  
Fax Number (410) 651-4083

St. Mary's County Office  
of Environmental Health  
21580 Peabody Street-P.O. Box 316  
Leonardtown, Maryland 20650  
Telephone (301) 475-4321  
Fax Number (301) 475-4373

Talbot County Health Department  
215 Bay Street- Suite 4  
Easton, Maryland 21601  
Telephone (410) 770-6880  
Fax Number (410) 770-6888

Washington County Environmental Health  
13332 Pennsylvania Avenue  
Hagerstown, Maryland 21742  
Telephone (240) 313-3400  
Fax Number (240) 313-3424

Wicomico County Health Department  
Environmental Health  
108 East Main Street  
Salisbury, Maryland 21801  
Telephone (410) 546-4446  
Fax Number (410) 219-2882

Worcester Co Health Department  
Office of Environmental Health  
13070 St Martin's Neck Rd  
Bishopville, Maryland 21813  
Telephone (410) 352-3234  
Fax Number (410) 352-3369

# BUILDING SAFETY

For Youth Camps using a School (Public or Private)  
or a Government Owned Building or Property

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-4MD-MDH ext. 8417

## I. CAMP OPERATOR

If your youth camp is operating at a school (public or private) or a government owned building or property that is used by the public more than 170 days, complete the information in this section and forward this form to the building owner or the building owner's authorized representative.

CAMP OPERATOR NAME			PHONE		
CAMP NAME			SITE OWNER		
MAILING ADDRESS			SITE ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP

## II. BUILDING OWNER

This facility is seeking a youth camp certificate or letter of compliance from the Maryland Department of Health, Center for Healthy Homes and Community Services. Please complete the information below, and return the form to the camp operator listed above.

- The water supply is adequate, easily accessible to the campers, of a safe and sanitary quality and from an approved water supply system which is constructed, protected, operated and maintained in conformance with applicable State codes and local subdivision ordinances.
- The sewage disposal system is installed, operated, and maintained in conformance with applicable State codes and local subdivision ordinances.
- The plumbing at this building is installed, protected and maintained in conformance with applicable State codes and local subdivision ordinances.
- The electrical system at this building is installed and maintained in conformance with applicable State codes and local subdivision ordinances.
- The building is constructed and maintained in conformance with all fire and safety code requirements and is approved by the State or county fire authority.
- The building or property meets applicable local building and zoning approvals.

The camp operator should be aware of the following problems.

Water Supply: \_\_\_\_\_

Sewage Disposal: \_\_\_\_\_

Plumbing: \_\_\_\_\_

Electrical: \_\_\_\_\_

Fire Safety: \_\_\_\_\_

Zoning: \_\_\_\_\_

Other: \_\_\_\_\_

BUILDING OFFICIAL'S SIGNATURE	TITLE	DATE	PHONE
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**HEALTH  
PROGRAM**



Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps

Health Program

Purpose

The purpose of a written health program is to inform camp staff members and volunteers of the actions to follow to ensure each camper's health and safety while at camp.

Training

Staff members and volunteers must receive training in the health program. Training must include an opportunity to discuss the program and ask questions.

- Describe the training: what/where/when. Explain how you will document that each staff member or volunteer is trained before camp and knows the health program.

Knowledge and Conduct

Staff members and volunteers must know and follow the health program procedures.

Availability

A copy of the health program must be available to camp staff members. The health program must be on file in the headquarters or office of the camp.

- Where are copies of the health program kept?
- Do staff/volunteers receive a copy?

Health Supervisor

A health supervisor is a **physician, certified nurse practitioner or registered nurse** who provides health services for a camp. He/she must be licensed to practice in Maryland. The health supervisor may be a registered nurse licensed in another state if that state is on the list of Compact States. For a list of Compact States see the attached list or for the most current list see the Maryland Board of Nursing website at <http://www.mbon.org>.

- A health supervisor approves the health program annually by signing and dating the written program.
- Provide the printed name, title, license number, and state where the license is held of the camp's health supervisor on the signature page.
- Provide telephone numbers/address or other information on how to reach the health supervisor.

During camp hours, a health supervisor must be available for consultation. If your camper population consists of 50% or more campers with identified medical problems as defined in COMAR 10.16.07.02B(18), a health supervisor must be on site while camp is in operation.

Writing Health Program Procedures

Answer each question by describing your procedures or the actions you want your staff members to take:

1. How do you obtain Camper and Staff health information? (Provide copies of your forms)

2. Who reviews the health information?
3. When a camper's health form indicates an identified medical problem as defined in COMAR 10.16.07.02B(18), who contacts the camp's Health Supervisor to create a Plan of Action to deal with the day-to-day needs and medical emergencies of the camper?
4. How is camper health information shared with staff members that need to know?
5. How is confidential health information protected?
6. Who is responsible for being aware of any campers with easily discernable signs of injury or illness?
7. Do you provide any information on disease, illness or injury?
8. How do you handle emergencies and accidents?
9. Who has first aid training?
10. Who calls an ambulance or 911?
11. Who will care for and supervise an injured or ill camper until picked up by parent?
12. Do you have a health treatment area and where is it located?
13. Who will notify a parent when a camper is injured or ill and how is this done?
14. Who will report camper injuries and illnesses to the camp's Health Supervisor and Maryland Department of Health? Follow the attached chart.
15. Infectious disease prevention:
  - a. When are staff members required to wash their hands?
  - b. When is personal protective equipment required?
  - c. What is the camp's standard for personal hygiene?
  - d. Does the camp have an exposure control plan?
16. Who is the Health Supervisor? Remember to include the name, title, license number and State license held in of the camp's health supervisor.
17. How can the Health Supervisor be contacted? Provide telephone/beeper numbers/address or other information on how to reach the camp's health supervisor.
18. Is the Health Supervisor on-site if 50% or more campers have identified medical problems as defined in COMAR 10.16.07.02B(18)?
19. Is the signature page included? Each year the camp's Health Supervisor must sign and date that they have approved the camp's Health Program.
20. Keep the original Health Program on file at camp headquarters/office.



21. Make sure the Health Program is available to staff members while the camp is operating.
22. Ensure that all health forms are retained for 3 years. This includes the following forms:
  - a. Incident Report Form
  - b. Medication Administration Authorization Form
  - c. Medication Administration Form
  - d. Medication Final Disposition Form

#### Camper Medication Administration

23. How will the camp operator obtain written authorization from both the parent/guardian and the prescriber? (Indicate use of MDH-4758, Medication Administration Authorization Form or your form. If using your own form, see question 44 below.)
24. How will the camp operator ensure that, except at a primitive camp, if an emergency medication or while a medication is being administered, medications are kept in a locked storage compartment?
25. How will the camp operator ensure that a prescription medication is kept in the original container bearing a pharmacy label that includes the:
  - (a) Prescription number;
  - (b) Date filled;
  - (c) Authorized prescriber's name;
  - (d) Patient's name;
  - (e) Name of the medication;
  - (f) Dose of the medication;
  - (g) Route of administration for the medication;
  - (h) Time or frequency of administration for the medication; and
  - (i) Expiration date;
26. How will the camp operator ensure that nonprescription medications are kept in an original container that includes the directions for use?
27. How will the camp operator ensure that medication is given to the camper from the original container?
28. How will the camp operator ensure that the directions provided in the prescriptive order for the medication found on the Medication Administration Authorization Form or the standing order are followed?

29. How will the camp operator ensure that the staff member or designated volunteer administering the medication or supervising a camper who is self-administering medication knows the side effects and toxic effects of the medication?
30. How will the camp operator ensure that medication is kept in a secure manner?
31. How will the camp operator ensure that emergency medications are handled according to the following:
- (1) Except as allowed in COMAR 10.16.07.15, an operator shall ensure that:
- (a) Emergency medication is:
    - (i) Carried by the camper needing the medication if authorized by both the parent or guardian and a licensed or authorized prescriber to self-carry the medication;
    - (ii) Carried by an adult staff member or volunteer directly supervising the camper; or
    - (iii) Stored at a designated easily accessible location; and
  - (b) Emergency medication is administered by:
    - (i) The camper so long as the camper is capable and authorized by both the parent or guardian and a licensed or authorized prescriber to self-administer the medication;
    - (ii) An adult staff member or volunteer meeting the following requirements:
      - I. A licensed or certified professional:
        - [a] Who is authorized to practice in Maryland; and
        - [b] Whose scope of practice includes medication administration; or
      - II. An adult staff member or a volunteer who:
        - [a] Is designated by the operator; and
        - [b] On an annual basis successfully completes a training course approved annually by the Department; or
    - (iii) An adult staff member or volunteer trained by a health supervisor.
- (2) An operator may allow a camper to self-carry an emergency medication if both the parent or guardian and a licensed or authorized prescriber have provided written consent for the camper to self-carry the emergency medication.

32. How will the camp operator ensure that the medication is stored according to the manufacturer's directions?
33. How will the camp operator ensure that a staff member or designated volunteer documents medication administration on a Medication Administration Form? (Indicate use of DHMH-4759, Medication Administration Form or your form. If using your own form, see question 45 below.)
34. How will the camp operator ensure that a staff member or designated volunteer documents the final disposition of the medication on a Medication Final Disposition Form? (Indicate use of DHMH-4760, Medication Final Disposition form or your form. If using your own form, see question 46 below.)
35. How will the camp operator ensure that within 2 weeks after the end of the camping session or when the medication is discontinued, the medication is:
- a. Returned to:
    - i. The parent;
    - ii. The guardian;
    - iii. An individual designated by the parent or guardian who has authorization to pick-up the camper and the medication;
    - iv. Camper, if authorized by the parent or guardian to take their medication with them at the end of the camping session; or
  - b. Destroyed
36. What is camp's policy on handling medication? (staff administration, camper self-administration or a combination of both)
37. Who administers medications if utilizing staff administration or who is the staff member / volunteer designated to supervise camper self-administration at camp?
38. Is the individual administering medication licensed or trained to do so? (Indicate license or training, such as registered nurse, certified medication technician, or 6-hour medication administration course by Maryland State Department of Education (MSDE))

Staff Member or Volunteer Medication Administration

39. How will the camp operator provide a means to secure medication for a staff member or volunteer when a medication is brought to camp?
40. How will the camp operator ensure that all staff member or volunteer medications are maintained in a secure manner at all times?
41. Will staff members or volunteers self-administer their medication or is there a designated staff member or volunteer that will administer medication to all other staff members or volunteers?

42. If a designated staff member or volunteer will administer medication to all other staff members or volunteers, then:

- c. How will the camp operator ensure that a staff member or volunteer provides written authorization on a medication administration authorization form for each medication brought to camp? (A staff member or volunteer who is an adult may sign their own medication administration authorization form in lieu of a parent or guardian.)
- d. How will the camp operator ensure that the following forms, per medication, are on file for each staff member or volunteer taking medication:
  - i. A Medication Administration Authorization Form?
  - ii. A Medication Administration Form?
  - iii. A Medication Final Disposition Form?
- e. How will the camp operator ensure that the forms required above are retained for 3 years and made available to the Department for review?

Electronic Health Records

*(Only answer 43 if your camp uses electronic health records.)*

43. In the event of a power outage or loss of connection to server, how will the camp operator ensure:

- f. Access to camper, staff and volunteer health information?
- g. Document injuries, illnesses and other reportable diseases and conditions in a paper health log?
- h. Document medication administration on a paper form?

Medication Administration Forms

*(Only answer 44-46 if your camp uses its own medication administration forms.)*

44. If you are using your own medication administration authorization form, does it include the following required pieces: (Include a copy of your form for review)

F(1) The written prescriptive order for the medication that includes:

- (a) The child's name;
- (b) The child's date of birth;
- (c) The condition for which the medication is being administered;
- (d) Whether or not the medication is an emergency medication;
- (e) The name of the medication;
- (f) The dose of the medication;

- (g) The route of administration for the medication;
  - (h) The time or frequency of administration for the medication;
  - (i) If PRN, the frequency and for what symptoms the medication should be administered;
  - (j) The known side effects of the medication specific to the camper;
  - (k) The date medication administration shall begin;
  - (l) The date medication administration shall end, not to exceed 1 year from the beginning date;
  - (m) The authorized prescriber's name;
  - (n) The authorized prescriber's title;
  - (o) The authorized prescriber's telephone number;
  - (p) The authorized prescriber's fax number;
  - (q) The authorized prescriber's address;
  - (r) The authorized prescriber's signature; and
  - (s) The date the form is signed by the authorized prescriber;
- (2) The following statement: "I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA";
- (3) The parent's or guardian's signature;
- (4) The date the parent or guardian signed the form;
- (5) The parent's or guardian's primary phone number;
- (6) The parent's or guardian's alternative phone number;
- (7) If a camp allows a camper to self-administer medication, authorization to self-administer medication that includes:

- (a) The following statement: "I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer";
  - (b) The signature of the authorized prescriber and the date the form is signed under the statement in §F(7)(a) of this regulation; and
  - (c) The signature of the parent or guardian and the date the form is signed under the statement in §F(7)(a) of this regulation; and
- (8) If a camp allows a camper to self-carry emergency medication, authorization to self-carry emergency medication that includes whether the:
- (a) Authorized prescriber gives permission for the child to self-carry emergency medication; and
  - (b) Parent or guardian gives permission for the child to self-carry emergency medication.

45. If you are using your own medication administration form, does it include the following required pieces: (Include a copy of your form for review)

- (1) Child's name;
- (2) Child's date of birth;
- (3) Name of the medication;
- (4) Dose of the medication;
- (5) Route of administration for the medication;
- (6) Time or frequency of administration for the medication;
- (7) Amount of medication administered;
- (8) Date and time of administration; and
- (9) Name of the individual who:
  - (a) Administered the medication to the child; or
  - (b) Supervised self-administration if the child self-administered the medication.

46. If you are using your own medication final disposition form, does it include the following required pieces: (Include a copy of your form for review)

- (1) The child's name;

- (2) The child's date of birth;
- (3) The name of the medication;
- (4) The final disposition of the medication;
- (5) Documentation that the medication is returned to the parent or guardian, or authorized individual, including the:
  - (a) Name of the individual to whom the medication was returned; and
  - (b) Signature of the staff member or volunteer who returned the medication; and
- (6) A section for documenting that the medication was destroyed that includes the:
  - (a) Signature of the individual responsible for destroying the medication;
  - (b) Signature of the individual witnessing the destruction of the medication; and
  - (c) Dates each individual signed the form.





**Maryland Department of Health  
Center for Healthy Homes and Community Services  
Youth Camps**

**Health Supervision and Medication Administration  
Frequently Asked Questions**

**A. Health Supervision**

1. Who can act as a Health Supervisor at a camp?

A Maryland licensed physician (MD), certified registered nurse practitioner (CRNP), and registered nurse (RN) can serve as a Health Supervisor at a youth camp.

2. How does one find a Health Supervisor?

The owner/operator of the day or residential youth camp can do a number of things to attract a Health Supervisor, including advertising in the local newspaper of the area where the camp is operating. In addition, one could search the Maryland Board of Nursing (MBON) web page for a RN known as a case manager/delegating nurse who is authorized to teach the Medication Technician Training Program. RNs who work in school health can frequently serve in the Health Supervisor position. This RN is also authorized to delegate and supervise the Certified Medication Technician (CMT). For a viewing of these RNs, please see the MBON web page at <http://mbon.maryland.gov>, click on Delegation under General on the left side of the screen. The MBON has temporarily removed the delegating RN list but will repost once it has verified the individuals on the list.

3. Is a Health Supervisor required to be on-site at the camp?

The youth camp regulations (COMAR 10.16.07.04) only require a Health Supervisor on-site at camp when 50% or more of the campers have identified

medical problems, as defined in COMAR 10.16.07.02B(18), such as asthma, cancer, diabetes, or epilepsy. Otherwise, a camp Health Supervisor must be available for consultation at all times when campers are present at camp. When the Health Supervisor is available for consultation and not on-site at the camp, the Department recommends that the Health Supervisor train camp staff members and volunteers during orientation. In addition, the Department recommends that the Health Supervisor, who is not on-site, (and instead consulting and delegating) performs an on-site visit at the beginning of camp to determine if the camp staff members and volunteers are knowledgeable and are implementing the approved health procedures appropriately.

If the Health Supervisor is a CRNP or RN, the CRNP or RN may only delegate medication administration to a competent person with the certification listed in B2. Therefore, the CRNP or RN must do an on-site visit at the beginning of camp to ensure competency of camp staff members and volunteers that are performing delegated nursing activities.

### **B. Administering Medications in a Youth Camp**

1. Do both day and residential youth camps need trained staff to administer medication?

If the day or residential camp is going to administer medications to campers, then yes, the camp must have trained staff at camp to administer medication.

2. Who can administer medication in a camp setting?

A Maryland licensed professional whose scope of practice includes medication administration, may administer medication in a camp setting. A

Maryland licensed health professional may include a Physician (MD), Certified Registered Nurse Practitioner (CRNP), registered nurse (RN), and licensed practical nurse (LPN). In addition, the RN, as the case manager, can also delegate and supervise medication administration to the Certified Medication Technician (CMT) and the Certified Medicine Aide (CMA). Also, an adult staff member or volunteer who is designated by the operator and on an annual basis successfully completes a training course approved annually by the Department may administer routine medication other than insulin.

3. Who is allowed to administer insulin at a camp?

Insulin may only be administered by a licensed or certified professional who is authorized to practice in Maryland and whose scope of practice includes medication administration.

4. What is the difference between the CMT and the CMA?

A Certified Medication Technician (CMT) is defined as an individual who completes a Maryland Board of Nursing (MBON) approved Medication Administration Training Program which is twenty (20) hours in length and who is certified by the MBON as a medication technician. An individual is not required to be a Certified Nursing Assistant (CNA) to become a Certified Medication Technician. The CMT can administer selected medications to individuals in the community based setting; including day and residential youth camps, when:

- A) A RN has delegated this function; and,
- B) The RN is available to supervise, instruct, and evaluate the CMT's performance.

The certified medicine aide (CMA) is an individual who is a CNA; has completed a MBON approved medicine aide-training program; and is certified as a CMA by the MBON. The individual wanting to be trained as a CMA must be certified as a CNA, hold the additional certification of GNA, have specific work experience, and have the recommendation of the Director of Nursing to attend the MBON approved 60-hour medicine aide training program.

5. How do I verify that a new or potential employee is a CMT or CMA?

An individual's status as a CMT or CMA can be verified by utilizing the MBON's web page at <http://mbon.maryland.gov>. To verify the status of an individual CMT, CMA or CNA, go to the web page and then click on License tab at the top. Click "Look Up a License". Scroll down and click "Proceed to look up your license / certification". Enter the individual's first and last name or license number. Click search.

6. How do I verify that staff member or volunteer has taken a medication administration course approved by the Department and is currently certified to administer medication at camp?

The individual, upon successful completion of a medication administration course approved by the Department, can apply to the Department to receive a Youth Camp Medication Administration Certification Card. The card will be valid for 1 year from the date the individual successfully completed the approved course. The card will also list the expiration date. An application to apply for a Youth Camp Medication Administration Certification Card is available on the Department's website under "Most Requested Forms and Documents," by

emailing the center at [mdh.envhealth@maryland.gov](mailto:mdh.envhealth@maryland.gov) or by calling the CHHCS office at 410-767-8417.

7. How does a medication administration course become approved by the Department?

An application to apply for Departmental approval of a medication administration course is available on the Department's website under "Most Requested Forms and Documents," by emailing the center at [mdh.envhealth@maryland.gov](mailto:mdh.envhealth@maryland.gov) or by calling the CHHCS office at 410-767-8417.

8. Is there a list of currently approved courses and instructors?

Yes, the Department has posted a list of approved courses on the Department's website under "Most Requested Forms and Documents". The list can also be obtained by emailing the center at [mdh.envhealth@maryland.gov](mailto:mdh.envhealth@maryland.gov) or by calling the CHHCS office at 410-767-8417.

9. Can a LPN or EMT/Paramedic administer medication or delegate medication administration to a CMT or CMA?

The LPN may administer medications in the camp setting. However, the LPN may not delegate or supervise the CMT or CMA to administer medication in the camp setting.

The EMT may not administer medication or delegate medication administration or supervise others in medication administration in a camp. The EMT/paramedic is licensed to provide care in the pre-hospital setting, e.g. an ambulance. The EMT/paramedic is eligible to be trained and certified as a CMT.

10. How many trained staff are necessary to administer medication at a camp?

A camp is not required to have all of its counselors are certified as a CMT, CMA, or Youth Camp Medication Administration Certification (YCMAC). However, a camp needs to train enough counselors to accommodate unique camp variables including, but not limited to the:

- Health of the campers (e.g. campers with identified medical problems versus healthy children)
- Number of campers at camp
- Length of time campers participate at camp (e.g. before and after camp programs or residential camp)
- Number of camp sessions (e.g. 5 days or 2 weeks)
- Camp activities (e.g. indoor or outdoor activities, on-site or off-site activities)
- Size, geographically, of the camp (e.g. all campers are in one community center for 4 hours a day versus a 10 acre camp with physical outdoor activities such as hiking).

The Health Supervisor should help to determine the number of trained staff members or volunteers necessary to administer medication at camp.

### **C. Self-Administration of Medication**

#### 1. What is self-administration of medication?

Self-administration of medication is when an individual is cognitively capable, has the ability to read, and has also developed the maturity necessary to be responsible for taking his or her own medication. Self-administration of

medication includes the ability to read the pharmacy dispensed medication container, prepare the right medication for self consumption by selecting the right amount of medication at the right time to be taken by the right route (e.g. oral, subcutaneous injection etc.) as prescribed by the MD or CRNP.

2. How old must the camper be to self-administer medication?

Whether a child can self administer his/her own medication depends on the age of the child; maturity of the child; how much education and training the child has received in self administration of medication and how much practice the child has had in self administering his/her own medication. Many times children 12 to 13 years of age can read well enough to select the right medication at the right time in the right dose and follow the directions on the medication container label. However, when campers self-administer medication, the camp must provide a responsible adult to observe and supervise the child in doing so.

The Department requires that the parent/guardian and prescriber make the determination as to whether or not a camper can or cannot self-administer medication. To authorize self-administration, both the parent/guardian and prescriber must sign the medication administration authorization form under the self-administration section. When a camper is permitted to self-administer medication, COMAR 10.16.07 requires the supervising adult to document when the dose is taken and that the medication is handled and stored properly.

3. Can a camper self-carry medication?

A camper may only self-carry an emergency medication if both the parent/guardian and prescriber have signed the medication administration authorization form consenting for the camper to do so. Self-carry is also only allowed for emergency medication if the camper maintains the medication being self-carried in a secure manner. If a camper fails to maintain the medication in a secure manner the camp operator must provide an alternative that complies with COMAR 10.16.07.

4. How are emergency medications handled at camp?

Unlike routine medication, emergency medication must be readily available to the camper in case the emergency for which the medication is prescribed presents itself. Therefore, emergency medication should be carried by either the camper needing the medication, if self-carry is authorized; an adult staff member or volunteer directly supervising the camper; or stored at a designated easily accessible location.

5. Who can administer emergency medication at camp?

Emergency medication may be administered by the camper, if self-administration is authorized and the camper is capable of doing so; an adult staff member or volunteer who is licensed or certified to administer medication; or an adult staff member or volunteer trained by the health supervisor.

6. What are standing orders and why are they used?

Standing orders are a prewritten medication order and specific instructions from a licensed or certified prescriber to administer a medication to an individual in clearly defined circumstances.



Camps may use standing orders to be able to provide medications such as Tylenol, Advil, antihistamines, etc. to campers that do not have their own prescriptive order for the medication on file at camp. The camp operator is still required to obtain parental consent before administering any medication in the standing order. A camp operator typically provides a check list of medications listed in the standing orders for the parent to indicate yes or no to administration for their child.

#### **D. General Questions**

1. During a field trip, how are medications administered and handled?

Care should be taken to ensure that medications taken on field trips are handled and stored according to the manufacturer's instructions. The CMT or CMA may not prepare or repackage medication for field trips. Only the Health Supervisor can prepare medications for a field trip.

The Health Supervisor will determine how best to package the camper's medication, where it is to be kept, and what adult will administer the medication or supervise a camper in self-administration. The Health Supervisor must provide specific training to adults accompanying the campers on how best to manage administration of that medication during the trip.

2. Should the camp be concerned about allergic reactions to drugs or food?

Allergic reactions to insects, food, or drugs can be very mild to very severe. The camp, regardless of its purpose, should always be prepared to intervene during an allergic reaction. The Health Supervisor can assist in

developing an emergency protocol designed to treat an individual with an allergic reaction. Most campers will have known allergic reactions and should have medical and prescriptive orders for use in the event of an allergic reaction. These orders must be reviewed by the camp's Health Supervisor and kept easily accessible to camp staff members or volunteers for treatment or in the event of an emergency.

3. Should a camp keep auto-injectable emergency epinephrine at camp for use in an emergency?

Allergic reactions to allergens such as food, insect stings, plants, or latex can be very severe. Every camp must be prepared to intervene during an emergency and have a written protocol for severe allergic reactions. The Health Supervisor should assist in developing this protocol. Decisions regarding epinephrine are based on specific camp variables discussed in Section B10.

When the camp includes a child or adult with a known history of a severe allergic reaction, the individual will have medical and prescriptive orders for use in the event of an emergency, including their own epinephrine prescribed by a physician for use at camp. The orders must be reviewed by the Health Supervisor, kept easily accessible to staff members and volunteers, and the Health Supervisor must train an appropriate number of adult staff members or volunteers at camp on how to administer the epinephrine.

4. Who can administer epinephrine's?

Epinephrine's are considered an emergency medication and are handled according to Sections B(4) and (5).

5. When a child has asthma, must the asthma inhaler be kept secure in the medication storage area?

Whether a child's inhaler should be kept in the medication storage area, with the adult counselor, or with the child is dependent on whether the inhaler is an emergency or routine medication and whether the child is authorized to self-carry the medication. If the asthma inhaler is an emergency medication then it is handled according to Sections B(4) and (5). Otherwise, the inhaler is handled as a routine medication.





## NLC Member States

	<u>Jurisdiction</u>	<u>Date Implemented eNLC</u>	<u>Date Withdrawn from Original NLC</u>
1	Alabama	1/01/20	N/A
2	Arizona	1/19/18	1/19/18
3	Arkansas	1/19/18	1/19/18
4	Colorado	1/19/18	7/18/18
5	Delaware	1/19/18	1/19/18
6	Florida	1/19/18	N/A
7	Georgia	1/19/18	N/A
8	Idaho	1/19/18	1/19/18
9	Indiana	TBD	N/A
10	Iowa	1/19/18	1/19/18
11	Kansas	7/01/19	N/A
12	Kentucky	1/19/18	1/19/18
13	Louisiana	7/01/19	N/A
14	Maine	1/19/18	1/19/18
15	Maryland	1/19/18	1/19/18
16	Mississippi	1/19/18	1/19/18
17	Missouri	1/19/18	1/19/18
18	Montana	1/19/18	1/19/18
19	Nebraska	1/19/18	1/19/18
20	New Hampshire	1/19/18	1/19/18
21	New Jersey	TBD	N/A
22	New Mexico	1/19/18	7/18/18
23	North Carolina	1/19/18	1/19/18
24	North Dakota	1/19/18	1/19/18
25	Oklahoma	1/19/18	N/A
26	South Carolina	1/19/18	1/19/18
27	South Dakota	1/19/18	1/19/18
28	Tennessee	1/19/18	1/19/18
29	Texas	1/19/18	1/19/18
30	Utah	1/19/18	1/19/18
31	Virginia	1/19/18	1/19/18
32	West Virginia	1/19/18	N/A
33	Wisconsin	1/19/18	6/11/18
34	Wyoming	1/19/18	N/A

\*The original compact dissolved July 18, 2018. RI is no longer a compact state as of 7/18/18.





# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

## INTERPRETIVE MEMORANDUM

**Date:** January 25, 2017

**To:** MD Youth Camp Operators

**From:** Joseph T. McKenzie, III, LEHS, REHS/RS, MPH, Chief  
Center for Healthy Homes and Community Services

**Re:** **REVISED POLICY: COMAR 10.16.07.14, Medications (Sunscreen)**

### **THIS MEMORANDUM SUPERSEDES ALL PREVIOUS INTERPRETIVE MEMORANDA REGARDING SUNSCREEN.**

Appropriate sunscreen use is important to prevent skin damage and skin cancer in children. The Department encourages the appropriate use of sunscreen during summer activities. At the same time, sunscreen can cause allergic reactions in a small number of children, and parents may wish to be involved in decisions regarding sunscreen use for their children.

1. The Center for Healthy Homes and Community Services no longer considers sunscreen a medication requiring a prescriptive order.
2. Camps shall obtain authorization from the parent/guardian before applying sunscreen at camp. The authorization shall include the camper's name, the parent or guardian's signature, the date signed, the brand of sunscreen and whether staff may assist the camper in the application of the sunscreen.
3. Camps should encourage parents/guardians to provide sunscreen. Camps are also permitted to provide sunscreen with approval by parents/guardians.
4. Parents/guardians should be encouraged to apply sunscreen to their child before the child attends camp for the day.

This policy is now in effect. Questions may be directed to the Office Help Line toll-free at 1-866-703-3266.

Cc: Claire Pierson, Assistant Attorney General  
Sabita Persaud, PhD, RN, APHN-BC, Maryland Board of Nursing





**CAMPER HEALTH HISTORY**

Child's Name: \_\_\_\_\_

**The following information is required:**

1<sup>st</sup> Emergency Contact  
(Parent or Legal Guardian): \_\_\_\_\_ Phone: \_\_\_\_\_

2<sup>nd</sup> Emergency Contact  
(Other than Parent Above): \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**HEALTH INFORMATION:**

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

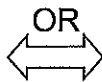
2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive?  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION INFORMATION:**

For campers who reside **within** the United States, a United States territory, or the District of Columbia:



For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides:

\_\_\_\_\_

2. Is this child exempt from any immunizations?  NO

YES, List them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Country in which child resides:

\_\_\_\_\_

2. Attach Department form MDH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**YOUTH CAMP HEALTH HISTORY**  
**STAFF MEMBER/VOLUNTEER**

Name: \_\_\_\_\_

Current residence: \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician or  
other provider of medical care: \_\_\_\_\_

**HEALTH INFORMATION:**

Are there any pertinent health problems including physical, psychiatric, or behavioral problems of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATION INFORMATION:**  
**Must list current residence above.**

For staff members/volunteers who currently reside **within** the United States, a United States territory, or the District of Columbia: Do you have any immunization exemptions because of a parental or guardian objection or medical contraindication?       NO

YES, List: \_\_\_\_\_

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

\_\_\_\_\_  
Staff Member/Volunteer Signature or  
Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)  
MDH-4767 (12/2017)

\_\_\_\_\_  
Date





## How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

### Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

# MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.
- An authorized individual must bring the medication to the camp and give the medication to an adult staff member.

## I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ____/____/____ Month Day Year		
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION <input type="checkbox"/> YES -If yes, see Section III below. <input type="checkbox"/> NO		
5. MEDICATION NAME	6. DOSE	7. ROUTE		
8. TIME/FREQUENCY OF ADMINISTRATION		9. IF PRN, FREQUENCY		
10. IF PRN, FOR WHAT SYMPTOMS				
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD				
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is <b>NOT TO EXCEED 1 YEAR.</b>		12a. FROM ____/____/____ Month Day Year	12b. TO ____/____/____ Month Day Year	
13. PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp		
TELEPHONE	FAX			
ADDRESS				
CITY	STATE			ZIP CODE
14a. PRESCRIBER'S SIGNATURE ( <i>Parent/guardian cannot sign here</i> ) <small>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</small>				14b. DATE

## II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15c. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION	
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #	

## III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

*This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.*

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE <small>authorizing self-administration</small>	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE <small>authorizing self-administration</small>	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. DATE





# MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities  
(410) 767-8417 or 1-877-463-3464 ext. 78417  
Draft Revision Date: 4/4/2018

<b>Section I. PRESCRIBER'S AUTHORIZATION</b>			
1. CHILD'S NAME (First Middle Last)			
2. DATE OF BIRTH (mm/dd/yyyy)			
3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.		3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)
Medication Name	Condition Being Treated/PRN Parameters	Dose	Route
1			Frequency
OK to Self-Carry (Emerg Meds Only)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med			
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
2			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med			
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
3			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med			
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
4. PRESCRIBER'S NAME/TITLE			
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(original signature or signature stamp only)</small>			
			5b. DATE (mm/dd/yyyy)
<b>Section II. PARENT/GUARDIAN AUTHORIZATION</b>			
I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.			
6a. PARENT/GUARDIAN SIGNATURE		6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
6d. HOME PHONE #		6f. WORK PHONE #	
6e. CELL PHONE #			
<b>Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)</b>			
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.			
I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."			
7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>		7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>
			8b. DATE



# MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities  
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417  
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

## Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy)
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3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.	3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)
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Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
4					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
5					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
6					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
7					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
8					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
9					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
10					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
11					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
12					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
13					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						

4. PRESCRIBER'S NAME/TITLE	This space may be used for the Prescriber's Address Stamp
TELEPHONE                      FAX	
ADDRESS	
CITY                      STATE                      ZIP CODE	

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <i>(original signature or signature stamp only)</i>	5b. DATE (mm/dd/yyyy)
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## Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

6a. PARENT/GUARDIAN SIGNATURE	6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
6d. HOME PHONE #	6e. CELL PHONE #	6f. WORK PHONE #

## Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>	7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>	8b. DATE
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# ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

## for Youth Camps in Maryland

Page 1 of 2

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities  
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

1. CHILD'S NAME (First Middle Last) \_\_\_\_\_ 2. DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_\_ 3. PEAK FLOW PERSONAL BEST: \_\_\_\_\_

4. ASTHMA SEVERITY (check one):  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise Induced

5. ASTHMA TRIGGERS (check all that apply):  Colds  Exercise  Animals  Dust  Smoke  Food  Weather  Other \_\_\_\_\_

**Section I: ASTHMA ACTION PLAN**

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9a below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.

**GREEN ZONE - DOING WELL**

You have ALL of these

Breathing is good  
No cough or wheeze  
Can walk, exercise, & play  
Can sleep all night  
if known, peak flow greater than \_\_\_\_\_ (80% personal best)

Medication Name	Dose	Route	Frequency	OK to Self-Administer
Rescue Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No

**YELLOW ZONE - GETTING WORSE**

You have ANY of these

Some problems breathing  
Wheezing, noisy breathing  
Tight chest  
Cough or cold symptoms  
Shortness of breath  
Other: \_\_\_\_\_  
if known, peak flow between \_\_\_\_\_ and \_\_\_\_\_ (50% to 79% personal best)

Medication Name	Dose	Route	Frequency	OK to Self-Administer
Rescue Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No

**RED ZONE - MEDICAL ALERT/DANGER**

You have ANY of these

Breathing hard and fast  
Lips or fingernails are blue  
Trouble walking or talking  
Medicine is not helping (15-20 mins?)  
Other: \_\_\_\_\_  
if known, peak flow below \_\_\_\_\_ (0% to 49% personal best)

Medication Name	Dose	Route	Frequency	OK to Self-Administer
Rescue Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Medication				OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No

6a. FROM (mm/dd/yyyy) \_\_\_\_\_ 6b. TO (mm/dd/yyyy) \_\_\_\_\_

# ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

## for Youth Camps in Maryland

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities

Page 2 of 2

Please complete this form if the child has an inhaler or other asthma-related medication

(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

CHILD'S NAME (First Middle Last)

DATE OF BIRTH (mm/dd/yyyy)

### Section II. PRESCRIBER'S AUTHORIZATION

8. PRESCRIBER'S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIP CODE

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)

9b. DATE (mm/dd/yyyy)

(original signature or signature stamp only)

### Section III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

10a. PARENT/GUARDIAN SIGNATURE

10b. DATE (mm/dd/yyyy)

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. HOME PHONE #

10e. CELL PHONE #

10f. WORK PHONE #

### Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I; Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I; Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY

11b. DATE (mm/dd/yyyy)

12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY

12b. DATE (mm/dd/yyyy)

### Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:

Reviewed by:

DATE (mm/dd/yyyy)

MDH-4758-C (01/2019)

Please turn over - this form has 2 pages with four total sections

Keep for 3 Years







# MEDICATION FINAL DISPOSITION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	Date of Birth:
Medication Name:	Final Disposition: <input type="checkbox"/> Returned (Complete Section A) <input type="checkbox"/> Destroyed (Complete Section B)
Section A	
MEDICATION RETURNED TO (NAME)	DATE
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	DATE
Section B	
The above indicated medication was not retrieved by the parent/guardian or authorized individual within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.	
SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	DATE
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	DATE

KEEP FOR 3 YEARS



**MARYLAND YOUTH CAMP  
INCIDENT REPORT FORM**

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608  
Phone 410-767-8417 Toll Free 1-877-4MD-MDH, ext.8417 Fax 410-333-8926

A. PERSONAL INFORMATION				
1. Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper <input type="checkbox"/> Camp Employee <input type="checkbox"/> Other:	
B. INCIDENT INFORMATION Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.				
5. Report Type (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Medication Error <input type="checkbox"/> Epinephrine	6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
8. Provide short description, do not include names:			<input type="checkbox"/> Additional information attached	
9. Did the incident require any of the following: AED: <input type="checkbox"/> No <input type="checkbox"/> Yes CPR: <input type="checkbox"/> No <input type="checkbox"/> Yes Epinephrine: <input type="checkbox"/> No <input type="checkbox"/> Yes Inhaler: <input type="checkbox"/> No <input type="checkbox"/> Yes				
10. Was the person transported off-site for medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete A. and B. A. Transported by: <input type="checkbox"/> Camp vehicle <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter B. Treated or evaluated at (check all that apply, specify the name of facility): <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify) _____	11. After off-site or on-site medical evaluation, the person (check all that apply): <input type="checkbox"/> Was admitted to the hospital <input type="checkbox"/> Went home. Date _____ <input type="checkbox"/> Returned to camp with medical restrictions <input type="checkbox"/> Returned to camp with no restrictions	13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes		
12. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes List Date of death: / / List Time of death: <input type="checkbox"/> am/ <input type="checkbox"/> pm		14. Did the incident prompt a report or investigation by government authorities or officials? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) Government Agency _____ Report/Investigation Date _____ Report/Investigation Number _____		
C. INJURY (15 through 22)				
15. What caused the injury: (check one, specify below) <input type="checkbox"/> Bite <input type="checkbox"/> Burn <input type="checkbox"/> Contact/collision with <input type="checkbox"/> Person or <input type="checkbox"/> Object <input type="checkbox"/> Drowning <input type="checkbox"/> Near-Drowning <input type="checkbox"/> Fall <input type="checkbox"/> Trip/Slip <input type="checkbox"/> Hazardous Material Exposure <input type="checkbox"/> Poisoning <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify) specify by what _____	18. Specify the body part(s) injured: _____ 19. Describe where the injury occurred: <input type="checkbox"/> On Site <input type="checkbox"/> Off Site (specify location) _____ 20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity): <input type="checkbox"/> Archery <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Biking <input type="checkbox"/> Boating (specify) _____ <input type="checkbox"/> Competitive Sport/Game (specify): _____ <input type="checkbox"/> Cooking/Food Preparation <input type="checkbox"/> Fighting <input type="checkbox"/> General Camp Life (specify) _____ <input type="checkbox"/> Groundskeeping/Maintenance (staff only) <input type="checkbox"/> Gymnastics/Dance/Cheerleading <input type="checkbox"/> Horseback Riding		20. Continued <input type="checkbox"/> Motorized Vehicle (specify) _____ <input type="checkbox"/> Playground <input type="checkbox"/> Primitive Camping <input type="checkbox"/> Rifery <input type="checkbox"/> Rock Climbing/Rappelling <input type="checkbox"/> Ropes Course/Challenge Course/Zip-line <input type="checkbox"/> Swimming <input type="checkbox"/> Walking/Running/Hiking <input type="checkbox"/> Other (specify) _____	
16. Was the injury: <input type="checkbox"/> Unintentional (accidental) <input type="checkbox"/> Intentional (self-inflicted) <input type="checkbox"/> Intentional (inflicted by another)	17. Did the individual sustain a (check all that apply): <input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> None of above		21. Was the activity supervised? <input type="checkbox"/> Not Applicable <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) # of campers in activity _____ # of staff in activity _____	
22. Was the individual using safety equipment? <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes (specify) _____				
D. ILLNESS 23. MDH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.				
A. Was the illness a suspected reportable disease, condition or outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes For the required MDH reportable diseases list and outbreak information go to: <a href="http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf">http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/ReportableDisease_HCP.pdf</a>				
B. Was the illness reported to a local health department? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes (specify department): _____ The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency go to: <a href="http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/DHMH1140.pdf">http://phpa.health.maryland.gov/IDEHSharedDocuments/what-to-report/DHMH1140.pdf</a>				
E. MEDICATION ERROR 24. Right Patient? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Medication? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Time? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Dose? <input type="checkbox"/> No <input type="checkbox"/> Yes; Right Route? <input type="checkbox"/> No <input type="checkbox"/> Yes				
25. Type of administration: <input type="checkbox"/> Self-Administration: Was camp staff supervising the self-administration? <input type="checkbox"/> No <input type="checkbox"/> Yes Was medication secured? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Staff administration: Staff person's training level (check one): <input type="checkbox"/> Office of child care (6 hour course) <input type="checkbox"/> Certified Medication Technician <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> CNP				
F. EPINEPHRINE 26. Who administered the epinephrine? Name and Title: _____				
27. Was the epinephrine prescribed to: the individual? <input type="checkbox"/> or the Camp, Epinephrine Certificate Holder? <input type="checkbox"/> No <input type="checkbox"/> Yes				
28. Trigger: <input type="checkbox"/> Unknown or <input type="checkbox"/> Known: (specify): _____				
29. Symptoms (check all that apply): <input type="checkbox"/> Skin reaction, <input type="checkbox"/> Feeling of warmth, <input type="checkbox"/> Sensation of a lump in the throat, <input type="checkbox"/> Constriction of the airway, swollen tongue, trouble breathing, <input type="checkbox"/> Rapid pulse, <input type="checkbox"/> Nausea, vomiting or diarrhea, <input type="checkbox"/> Dizziness or fainting				
30. Report Completed By-Employee Name (print)			Title	
31. Camp Name		Address	MDH CAMP ID #	
32. Notification	Parent, Guardian, or Emergency Contact was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date	
	Camp Health Supervisor was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Date	
	MDH/CHS was notified within 24 hours	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Date	
33. Employee Signature		Date	Phone Number	



**REQUIRED HEALTH REPORTS, COMAR 10.16.07.06**

<b>Make Report To: ⇨ Type:</b>	<b>Minor's Parent/Guardian</b>	<b>Health Supervisor</b>	<b>MDH</b>	<b>Health Log or Personal Health Record</b>
<b>Injury or illness that results in death, requires CPR, or admission to a hospital. (See COMAR 10.16.07.06A)</b>	Immediately	Immediately	Verbally within 24 hours and submit the Report Form* within 1 week	Record same day
<b>Injury that is treated at an off-site medical facility and has a positive diagnosis (See COMAR 10.16.07.06B)</b>	Immediately	Immediately	Submit the Report Form* within 4 weeks of the end of camp	Record same day
<b>Accident with no apparent injury Example: a fall from a horse/equipment or impact from sports equipment. (See COMAR 10.16.07.06C+D)</b>	If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written)	Immediately if Health Supervisor is on duty at camp	No report	Record same day
<b>All other injuries &amp; illnesses</b>	If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written)	No report	No report	Record same day
<b>Reportable conditions or outbreaks per COMAR 10.06.01, see list</b>	Immediately	Immediately	Verbally to MDH and Local Health Department within 24 hours and submit the Report Form* to DHMH within 1 week.	Record same day
<b>Medication Error or Auto-injectable Epinephrine</b>	Immediately	Immediately	Submit the Report Form* within 4 weeks of the end of camp	Record same day

Maintain documentation of reports at camp.

**\*Before forwarding reports to MDH, remove confidential information such as person's name.**

**DO NOT REMOVE AGE, GENDER OR DATE/TIME OF INCIDENT.**

MDH, Center for Healthy Homes and Community Services

6 St Paul St, Suite 1301

Baltimore, MD 21202-1608

Phone: 410-767-8417

Fax: 410-333-8926



# YOUTH CAMP MEDICATION ADMINISTRATION CERTIFICATE HOLDER APPLICATION

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-4MD-MDH ext. 8417

<b>I. APPLICANT</b>					
CAMP APPLICANT NAME		CAMP NAME		CAMP LICENSE NUMBER	
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE		
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE		
APPLICANT'S EMAIL					
<b>II. AGE</b>					
ARE YOU AN ADULT, AS DEFINED IN COMAR 10.16.06 AND 10.16.07?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>III. TRAINING COURSE</b>					
A) HAVE YOU SUCCESSFULLY COMPLETED A MEDICATION ADMINISTRATION COURSE APPROVED BY THE DEPARTMENT?					
		<input type="checkbox"/> YES	<input type="checkbox"/> NO		
B) NAME OF APPROVED COURSE					
C) HAVE YOU ATTACHED A COPY OF YOUR COMPLETION CERTIFICATE?					
		<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>V. APPLICANT'S SIGNATURE</b>					
<p>I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-MDH ext. 78417.</i></p>					
X _____		DATE _____			
APPLICANT'S SIGNATURE					
<b>FOR INTERNAL USE ONLY (Do Not Write Below This Line)</b>					
TRACKING #: _____					
<input type="checkbox"/> APPROVED					
<input type="checkbox"/> DENIED Reason: _____					
X _____		DATE _____			
CHHCS CHIEF'S SIGNATURE					





# YOUTH CAMP MEDICATION ADMINISTRATION COURSE APPLICATION

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-463-3464 ext. 78417

<b>I. APPLICANT INFORMATION</b>			
APPLICANT'S NAME			
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
<b>II. BUSINESS INFORMATION</b>			
BUSINESS NAME			
BUSINESS MAILING ADDRESS		CITY	STATE ZIP CODE
NAME OF TRAINING			
<b>III. INSTRUCTOR CREDENTIALS (FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMATION ON ANOTHER SHEET OF PAPER)</b>			
INSTRUCTOR'S NAME			
WHICH LICENSE TYPE DO YOU HOLD?			
<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> REGISTERED NURSE <input type="checkbox"/> CERTIFIED NURSE PRACTITIONER			
LICENSE NUMBER:			
<b>IV. WRITTEN MATERIALS</b>			
SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:			
A) Training manual B) All handouts B) All presentations C) All exams D) Certificate issued to student upon completion			
<b>V. APPLICANT'S SIGNATURE</b>			
I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding routine medication, except for insulin, at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-MDH ext. 78417.</i>			
X _____ APPLICANT'S SIGNATURE		_____ DATE	
<b>FOR INTERNAL USE ONLY (Do Not Write Below This Line)</b>			
<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED Reason: _____		TRACKING #: _____	
X _____ EHB DIRECTOR'S SIGNATURE		_____ DATE	



# YOUTH CAMP MEDICATION ADMINISTRATION CERTIFICATE HOLDER APPLICATION

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-463-3464 ext.78417

<b>I. APPLICANT</b>			
CAMP APPLICANT NAME		CAMP NAME	CAMP LICENSE NUMBER
APPLICANT'S MAILING ADDRESS		APPLICANT'S WORK PHONE	
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
<b>II. AGE</b>			
ARE YOU AN ADULT, AS DEFINED IN COMAR 10.16.06 AND 10.16.07?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>III. TRAINING COURSE</b>			
A) HAVE YOU SUCCESSFULLY COMPLETED A MEDICATION ADMINISTRATION COURSE APPROVED BY THE DEPARTMENT?			
<input type="checkbox"/> YES		<input type="checkbox"/> NO	
B) NAME OF APPROVED COURSE			
C) HAVE YOU ATTACHED A COPY OF YOUR COMPLETION CERTIFICATE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>V. APPLICANT'S SIGNATURE</b>			
<p>I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-MDH ext. 78417.</i></p>			
X _____		DATE _____	
APPLICANT'S SIGNATURE			
<b>FOR INTERNAL USE ONLY (Do Not Write Below This Line)</b>			
TRACKING #: _____			
<input type="checkbox"/> APPROVED			
<input type="checkbox"/> DENIED		Reason: _____	
X _____		DATE _____	
CHHCS CHIEF'S SIGNATURE			



# EMERGENCY EPINEPHRINE TRAINING PROGRAM APPLICATION

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202-1608  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-4MD-MDH ext. 8417

I. APPLICANT INFORMATION			
APPLICANT'S NAME			
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			
II. BUSINESS INFORMATION			
BUSINESS NAME			
BUSINESS MAILING ADDRESS	CITY	STATE	ZIP CODE
NAME OF TRAINING			
III. INSTRUCTOR CREDENTIALS (FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMATION ON ANOTHER SHEET OF PAPER)			
INSTRUCTOR'S NAME			
WHICH LICENSE TYPE DO YOU HOLD?			
<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> REGISTERED NURSE <input type="checkbox"/> CERTIFIED NURSE PRACTITIONER			
LICENSE NUMBER:			
IV. WRITTEN MATERIALS			
SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:			
A) Training manual, to include all requirements list in COMAR 10.16.07.15D B) All handouts B) All presentations C) All exams D) Certificate issued to student upon completion			
V. APPLICANT'S SIGNATURE			
I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.07 of the State of Maryland regarding emergency epinephrine at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.</i>			
X _____ APPLICANT'S SIGNATURE			DATE _____
FOR INTERNAL USE ONLY (Do Not Write Below This Line)			
<input type="checkbox"/> APPROVED		<input type="checkbox"/> DENIED Reason: _____	
		TRACKING #: _____	
X _____ EHB DIRECTOR'S SIGNATURE			DATE _____



**ANNUAL**

**REPORT**





# Youth Camp Safety Advisory Council Annual Report

Maryland Department of Health (MDH)  
Center for Healthy Homes and Community Services (CHHCS)  
6 St. Paul Street, Suite 1301, Baltimore, MD 21202-1608  
Phone (410) 767-8417 or Toll Free 1-877-463-3464 ext 78417  
Fax (410) 333-8926

YEAR: \_\_\_\_\_  Revised copy

- At the end of your camping season, please complete the information below and submit the completed form to the Maryland Department of Health (MDH) at the above address or fax number. Maryland Certification for Youth Camps, COMAR 10.16.06.06, requires that an operator files an annual report and any required injury/illness reports within 4 weeks of the end of camp.
- If you do not submit an annual report and any required incident reports within 4 weeks of the end of camp, you are in violation of the Certification for Youth Camp Regulations, COMAR 10.16.06.06. According to Certification for Youth Camp Regulations, COMAR 10.16.06.14 this Office may deny your renewal application for failure to submit this annual report and any required incident reports and camp will not be eligible for "Good Standing" with the Department or be allowed to pay the reduced fee.

→ Camp Name \_\_\_\_\_ Certificate # \_\_\_\_\_

→ Camp Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

→ Complete the following chart with the understanding that a camp may operate continuously throughout the season or with breaks in operation (i.e. weekends).

Week	Weekly Operation Dates		# of Days (A)	# of Campers (B)	# of Camper Days (A x B)	# of Reportable Injuries	# of Reportable Diseases/ Conditions	# of Medication Errors	# of Epi-nephrine	# of Fatalities	# of Staff
	Start Date (MM/DD/YY)	End Date (MM/DD/YY)									
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
Please Total These Columns →→→											

If not previously done, submit the required incident report form(s) to MDH, for each individual involved, with this annual report. In order to maintain confidentiality, remove camper/staff member's name and other personal identifiers from the completed incident report form before submitting.

→ Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

→ Print Name and Title of Person Completing this Form \_\_\_\_\_

→ Print Email of Person Completing this Form \_\_\_\_\_



**COMPLIANCE  
SCHEDULE**



# COMPLIANCE SCHEDULE APPLICATION

Maryland Department of Health (MDH)  
 Center for Healthy Homes and Community Services (CHHCS)  
 6 St. Paul Street, Suite 1301  
 Baltimore, Maryland 21202-1608  
 (410) 767-8417 FAX (410) 333-8926  
 Toll Free 1-877-4MD-MDH ext. 8417

I. Camp Owner Information		
NAME OF OWNER		
MAILING ADDRESS OF OWNER		
CITY	STATE	ZIPCODE
II. Camp Information		
CAMP NAME		
PHYSICAL ADDRESS		
CITY	STATE	ZIPCODE
TYPE OF FACILITY	<input type="checkbox"/> DAY CAMP <input type="checkbox"/> RESIDENTIAL CAMP <input type="checkbox"/> DAY & RESIDENTIAL CAMP <input type="checkbox"/> TRIP CAMP <input type="checkbox"/> TRAVEL CAMP	
III. Compliance Information		
SPECIFY THE NONCOMPLIANT ITEM		
SPECIFY THE REASON THAT THE NONCOMPLIANT ITEM CANNOT BE IMMEDIATELY CORRECTED		
EXPLAIN THE PLAN FOR CORRECTING THE NONCOMPLIANT ITEM		
GIVE THE TIME SCHEDULE FOR CORRECTING THE NONCOMPLIANT ITEM		
IV. Signature		
SIGNATURE OF OWNER OR AUTHORIZED REPRESENTATIVE		DATE
PHONE NUMBER	EMAIL ADDRESS	
For Office Use Only		
DOES OPERATION DURING THE TIME ALLOWED TO BRING THE YOUTH CAMP INTO COMPLIANCE ADVERSELY AFFECT THE HEALTH AND SAFETY OF THE PUBLIC?		
<input type="checkbox"/> YES		<input type="checkbox"/> NO
COMPLIANCE SCHEDULE IS:		
<input type="checkbox"/> APPROVED		<input type="checkbox"/> DISAPPROVED
ENVIRONMENTAL HEALTH SPECIALIST'S SIGNATURE		DATE



**VARIANCE**

**REQUEST**





# VARIANCE REQUEST APPLICATION

Maryland Department of Health (MDH)  
 Center for Healthy Homes and Community Services (CHHCS)  
 6 St. Paul Street, Suite 1301  
 Baltimore, Maryland 21202-1608  
 (410) 767-8417 FAX (410) 333-8926  
 Toll Free 1-866-703-3266

I. Camp Owner Information		
NAME OF OWNER		
MAILING ADDRESS OF OWNER		
CITY	STATE	ZIPCODE
II. Camp Information		
CAMP NAME		
PHYSICAL ADDRESS		
CITY	STATE	ZIPCODE
TYPE OF FACILITY	<input type="checkbox"/> DAY CAMP <input type="checkbox"/> RESIDENTIAL CAMP <input type="checkbox"/> DAY & RESIDENTIAL CAMP <input type="checkbox"/> TRIP CAMP <input type="checkbox"/> TRAVEL CAMP	
III. Variance Request Information		
SPECIFY THE APPLICABLE REGULATION TO WHICH THE VARIANCE REQUEST PERTAINS		
EXPLAIN THE REASON FOR THE VARIANCE REQUEST		
GIVE SPECIFIC DETAILS OF THE PROPOSED ALTERNATIVE PROCEDURE		
IV. Signature		
SIGNATURE OF OWNER OR AUTHORIZED REPRESENTATIVE		DATE
PHONE NUMBER	EMAIL ADDRESS	
For Office Use Only		
IS THE APPLICATION JUSTIFIED DUE TO PHYSICAL LIMITATION OF THE EXISTING LAYOUT OF THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES THE ALTERNATIVE PROCEDURE MEET OR PRODUCE THE INTENDED EFFECT OF THE REGULATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES THE ALTERNATIVE PROCEDURE MAINTAIN THE PROTECTION OF THE HEALTH AND SAFETY OF THE INDIVIDUALS USING THE FACILITY AT OR ABOVE THE LEVEL REQUIRED BY THE REGULATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
COMPLIANCE SCHEDULE IS: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (see above reason)		
ENVIRONMENTAL HEALTH SPECIALIST'S SIGNATURE		DATE



## **NOTICE TO THE PUBLIC**

### **NON-DISCRIMINATION STATEMENT AND ACCESSIBILITY REQUIREMENTS**

The Department of Health and Mental Hygiene (the Department) complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

The Department, upon request:

- Provides free aids and services to people with disabilities to communicate effectively with Department staff, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Environmental Health Bureau directly.

If you believe that the Department has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Delinda Johnson, Equal Access Compliance Unit, Office of Equal Opportunity Programs, Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Room 514, Baltimore, Maryland 21201, 410-767-6600 (voice), 1-800-735-2258 (TTY), (410) 333-5337 (Fax), [delinda.johnson@maryland.gov](mailto:delinda.johnson@maryland.gov) (email).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Delinda Johnson is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Interpreter Services Are Available for Free

Help is available in your language: 410-767-8400 (TTY: 1-800-735-2258).

These services are available for free.

### Español/Spanish

Hay ayuda disponible en su idioma: 410-767-8400 (TTY: 1-800-735-2258). Estos servicios están disponibles gratis.

### አማርኛ/Amharic

እገዛ በ ቋንቋዎ ማግኘት ይችላሉ፡-: 410-767-8400 (TTY: 1-800-735-2258) #

እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻ ናቸው።

### العربية/Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 410-767-8400 (رقم هاتف

الصم والبكم: (1-800-735-2258)

### 中文/Chinese

用您的语言为您提供帮助: 410-767-8400 (TTY: 1-800-735-2258)。这些服务都是免费的

### فارسی/Farsi

خط تلفن کمک به زبانی که شما صحبت می کنید: 1-800-735-2258 (خط تماس افراد ناشنوا 1-800-000-0000)

این خدمات به صورت رایگان در دسترس هستند

### Français/French

Vous pouvez disposer d'une assistance dans votre langue: 410-767-8400 (TTY: 1-800-735-2258). Ces services sont disponibles pour gratuitement.

### ગુજરાતી/Gujarati

તમારી ભાષામાં મદદ ઉપલબ્ધ છે: 410-767-8400 (ટીટીવાય: (TTY: 1-800-735-2258). સેવાઓ મફત ઉપલબ્ધ છે

### kreyòl ayisyen/Haitian Creole

Gen èd ki disponib nan lang ou: 410-767-8400 (TTY: 1-800-735-2258). Sèvis sa yo disponib gratis.

### Igbo

Enyemaka di na asusu gi: 410-767-8400 (TTY: 1-800-735-2258). Oṣu ndị a dị na enweghi ugwo i ga akwu maka ya.

### 한국어/Korean

사용하시는 언어로 지원해드립니다: 410-767-8400 (TTY: 1-800-735-2258). 무료로 제공 됩니다

### Português/Portuguese

A ajuda está disponível em seu idioma: 410-767-8400 (TTY: 1-800-735-2258). Estes serviços são oferecidos de graça.

**Русский/Russian**

Помощь доступна на вашем языке: 410-767-8400 (TTY: 1-800-735-2258). Эти услуги предоставляются бесплатно.

**Tagalog**

Makakakuha kayo ng tulong sa iyong wika: 410-767-8400 (TTY: 1-800-735-2258). Ang mga serbisyong ito ay libre.

**اردو/Urdu).**

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال  
410-767-8400 (TTY: 1-800-735-2258) کر

**Tiếng Việt/Vietnamese**

Hỗ trợ là có sẵn trong ngôn ngữ của quý vị 410-767-8400 (TTY: 1-800-735-2258). Những dịch vụ này có sẵn miễn phí.

**Yorùbá/Yoruba**

Ìrànlọwọ wà ní àrọwọtó ní èdè rẹ: 410-767-8400 (TTY: 1-800-735-2258). Awon ise yi wa fun o free.

**DEPARTMENTAL INFORMATION**

MARYLAND DEPARTMENT OF HEALTH  
PREVENTION AND HEALTH PROMOTION ADMINISTRATION  
ENVIRONMENTAL HEALTH BUREAU  
OFFICE OF HEALTHY HOMES AND COMMUNITIES

**CENTER FOR HEALTHY HOMES AND COMMUNITY SERVICES**

6 SAINT PAUL STREET, SUITE 1301  
BALTIMORE, MD 21202

PHONE: 410-767-8417

FAX: 410-333-8926

EMAIL:

[MDH.ENVHEALTH@MARYLAND.GOV](mailto:MDH.ENVHEALTH@MARYLAND.GOV)

