BTA Summer Sports Camps
Health Care Policy and Standing Orders

Brookline Tennis Academy Summer Camp at Roxbury Latin

101 Saint Theresa Avenue West

Roxbury, MA 02132

PH (617)-283-9812 www.brooklinetennisacademy.com

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Health Care Consultant Signature Date

Health Care Services Provided

During the majority of the camp season, Brookline Tennis Academy (BTA) Summer Camp maintains a Health Office staffed by one registered nurse and one athletic trainer. The nursing staff administers medication per physician's orders, assesses children who become ill while at camp, communicates with

camp families and administer first aid. The athletic trainer assesses children with orthopedic injuries, communicates with camp families and administer first aid. During the weeks that neither the nurse nor the athletic trainer are available, the Health Care Supervisor will be the main contact.

Health Care Consultant

Responsible for the development and approval of camp health care policies and available for consultation.

Nina Diggs, RN Nina.diggs@gmail.com

Health Care Supervisors

Shelly Mars Rodrigo Mendez Chris Jarrell

Yvonne Murphy

Responsible for the overall management of health care in camp including the reviewing of health records, compliance with health policies, health training of staff, and necessary treatment of illnesses and injuries.

Emergency Telephone Numbers Police **911**

Fire Rescue/Ambulance Poison Control Center **911**

Hospital

Brigham and Women's Faulkner Hospital 1153 Centre St. Jamaica Plain, MA 02130 (617) 983-7000

Procedures for Utilizing First Aid Equipment

First Aid medical kits located at:

- Athletic Training Room

First Aid Manual located at:

- Health Office
- Camp Office

First Aid is administered by Camp Nurses, Athletic Trainer, and Health Care Supervisors on campus.

First Aid Kits are all maintained by the Athletic Trainer.

First Aid Kit contents:

Sterile Water

Non/Sterile gauze squares Compresses

Adhesive tape

Sling

Band-aids

Non-latex gloves

Ice Pack

Automatic External Defibrillators (AEDs) and Epipens. Roxbury Latin has AEDs and EpiPens located in the following places:

1. In a cabinet mounted on the wall in the entry alcove down the hall opposite the Technology Office in the Perry Building
2. In a cabinet across from Room E15 in the Ernst Wing
3. In a cabinet outside the Palaistra
4. In a cabinet mounted in the foyer of the Smith Theater
5. In the Jarvis Refectory building on the wall opposite the kitchen.
6. In the foyer of the Gordon Field House.
7. In the men's room on the upper fields (during the Fall and Spring athletic seasons)
8. In the red backpack in the Athletic Training Room on the bottom shelf under the orange med kits or with the athletic trainer at a practice or game
9. In the Indoor Athletic Facility (IAF) – west side, outside of the First Aid Room
10. In the IAF – east side, inside of the Fitness Center

EpiPens. EpiPens containing epinephrine are stocked in the Athletic Trainer's office, the Nurse's Office, the Refectory and in the cabinet located in the Ernest Wing. Also, campers with prescribed EpiPens are asked to carry their own EpiPen with them at all times. There are several campers who have a documented risk for anaphylactic reaction and who have been prescribed an EpiPen. A list of these campers is kept by the Director's. **Campers who have a prescribed EpiPen and are suspected of having an anaphylactic reaction (explosive hives, swelling of lips, tongue, face, tightness in throat, difficulty breathing, nausea/stomach pain, confusion, sense of dread) should be given the EpiPen immediately.** Immediately after giving the EpiPen, call 911 to activate the Emergency Medical System, call the camper's parents and have the camper transported to the emergency room.

Make a note of the time you administered the EpiPen and give the empty syringe to Health Care Supervisor as soon as possible. **Epinephrine wears off very quickly. If symptoms return prior to EMS arriving you may administer a second EpiPen (5-10 minutes after first dose). It is essential that the student be transported by ambulance to the emergency room immediately. EPI = 911!**

Plan for Injury Prevention and Management

All camp staff are expected to regularly look over their own areas to identify and remove potential hazards. Accident reports are reviewed by the Director for trends or specific areas warranting attention.

Sanitation Monitoring

It is the primary responsibility of the Buildings and Grounds Dept. to ensure and monitor cleanliness throughout the camp facility. All staff are expected to assist in the effort by picking up trash and reporting spills. Building & Grounds personnel is available to assist in the clean-up of biohazard waste such as blood or bodily fluids.

Sun Protection Plan

All children are requested to come to camp with an initial sunscreen application (SPF30 or more). Sunscreen is reapplied periodically throughout the day with counselor assistance and supervision. Parents are asked to send their children with their own sunscreen. Hats and protective clothing are also recommended.

Reporting Procedures

In the event of serious injury, in-patient hospitalization, or death of camper or staff member, the Camp Director will notify the Department of Public Health. A written injury report shall be completed and be submitted to the Dept. of Public Health within seven days of the occurrence of the injury. In the case of all accidents and incidents, a BTA Accident Report will be completed and held by the BTA Director.

Informing Parents

Parents of campers who become ill during the camp day are contacted by the Camp Director. Parents are also called if their child experiences a head bump, injury to the face, an injury or illness which may need further evaluation, or a situation where the child seems very upset.

Infection Control Plan

Parents are asked to report communicable diseases to nursing staff and the Camp Director. Letters will be sent home immediately if outbreaks occur. Periodic head lice screening will occur at camp.

Blood Spill Procedures

All staff are instructed in universal precautions. Blood spill kits are available for clean up of any blood or body fluids. The buildings and grounds personnel is available for assistance with cleanup as needed. Latex gloves are available in all first aid med kits and are distributed in various locations around camp.

1. Non-latex disposable gloves must be worn in addi on to any other necessary personal protec ve equipment needed to protect the individual responsible for cleaning the blood spill from blood-

borne pathogens.

1. Use a disposable absorbent towel to clean the area of the spill as thoroughly as possible. Place soiled towels in contaminated materials bag.
2. All surfaces that have been in contact with the blood should be wiped with a 1:10 dilu on of household bleach can (this solu on should not be mixed in advance because it loses its

potency). After the disinfectant is applied, the surface should either be allowed to air dry, or else to remain wet for 10

minutes before being dried with a disposable towel or tissue.

1. A er disposable gloves are removed, they should be placed in contaminated materials bag and sealed and disposed of in a hazardous materials bin. Hands should be thoroughly washed with soap and water a er the gloves are removed.

Medication Administration Plan

Storage

All medications prescribed for campers shall be kept in the original container bearing the pharmacy label and stored in the health office in a locked cabinet used exclusively for medications. Medications requiring refrigeration shall be stored in a locked container in the nurse's refrigerator.

Prescription Medication

Prescription medication shall only be administered by the camp RNs or other staff as authorized by the camp's health care consultant. The Camp Director shall acknowledge in writing a list of all medications administered at camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container and there is written permission from the parent/guardian. Accurate written records shall be maintained of medications administered.

Non-prescription Drugs

Non-prescription drugs will be dispensed only if approved by a camper's parent/guardian on the health history form. Non-prescription drugs will be dispensed by the camp health care staff according to standing orders. Accurate written records shall be maintained of medications administered.

Unused Medication

Unused medication will be returned to campers' parents when no longer needed. On the camper's last day, the nurse or health care supervisor will have the head counselor hand the medication directly to parents at pick-up. If unable to do so, the camp nurse or health care supervisor will call parents to arrange a pick-up of the medication at camp.

General Health Maintenance

The Camp Director establishes a comprehensive health database of all campers after initial review of their medical information. All pertinent information is shared with Head Counselors through the use of lists generated by this database each session.

Care of Mildly Ill Campers

Mildly ill campers will be cared for based on standing orders. Campers unable to return to their group after 30 to 60 minutes will be sent home.

Exclusion Policy

The camp sets the guidelines for excluding children from camp due to illness, but we depend on parents to be our partners in promoting the health of campers and staff. Some symptoms that would call for a camper to remain at home are clear, such as a fever or obvious case of chicken pox. Some symptoms are more subjective, however. For the health and welfare of all campers concerned, the nurse may make an assessment that your child is too ill to be at camp. In such cases, she will call to ask you to pick up your child from camp. Please help us by responding promptly if we call you.

Furthermore, please keep your child at home if he/she experiences *any* of the following symptoms within 24 hours of the beginning of a new camp day:

- Fever of 100 degrees or higher (children should be fever-free and off Tylenol for 24 hours before returning to camp.)
- Recurrent diarrhea, vomiting, or significant nausea
- Flu-like symptoms
- Sore throat, particularly with swollen glands
- Cold symptoms such as repeated coughing or sneezing which are likely to spread infection
- Significant headache or stomach-ache
- Obvious infections such as chicken pox (all lesions should be crusted over before returning to camp)
- Contagious skin disease such as impetigo
- Any illness where a child is unable to fully participate in camp activities

NOTE: Children placed on antibiotics should be on them for 24 hours before returning to camp.

In all cases, please make sure to call the camp ahead of time to inform us that your child will not be attending camp due to illness on a given day. **Contingency Plans 1. Child who does not arrive at camp in the morning:**

- Double check attendance sheet and campers who are present in group
- Camp Director will initiate procedure to check if child has called in sick or if he/she will be arriving late.
- If neither is the case, Camp Director will initiate contact with parents to learn camper's whereabouts

2. Child who is missing from pick-up point in the afternoon:

- Double check attendance sheet to make sure child is in attendance on that day
- Have counselors check with Camp Director to see if child was picked up early or is in health office
- If unable to locate, initiate missing camper procedures

3. Unregistered child arriving at camp:

- Try to locate the child's parents if still on site

If unable to find parent...

- Bring camper to camp office
- Check camper's forms (if in camp's possession) for contact information
- Investigate which other children the camper may have arrived with
- Once contact information is obtained, call the child's parent/guardian

Emergency Planning and Crisis Response Procedures

SUMMER CRISIS RESPONSE PLAN

No two emergencies are the same. While the various steps and suggestions outlined in these procedures represent the camp's guidelines, your own good judgment should be the final authority until you are able to contact assistance. The safety and well-being of the campers and staff ALWAYS come first. What follows is the summary of BTA Summer Camp's Crisis Management Plan.

CRISIS MANAGEMENT TEAM (CMT)

The Crisis Management Team will direct the management of any sudden crisis. It will be limited in size to ensure its efficiency and clear authority in managing any crisis and will enlist the assistance of other available resources as needed to respond optimally to any crisis.

The Crisis Management Team will be composed of:

- Sean Spellman — Summer Programs Director (617)-981-1269
- Andy Chappell — Director of Studies (508)-212-9867
- Kerry Brennan — Headmaster (917)-862-7874
- Erin Berg — Director of Community Relations/ Media Inquiries
- Mike DoCurral — Director of Facilities (857)-325-4680
- Mike Pojman — Assistant Headmaster (508)-934-6655
- Shelly Mars — BTA Summer Camp Director – 617-283-9812
- **Nina Diggs, RN** — Health Consultant – Nina.diggs@gmail.com

Other individuals may be asked to join the team by the Head of School and Camp Director as needed. In managing any crisis, the Crisis Management Team will work closely with other members of the school community to determine the best course of action and to keep the school community informed of events and responses as the crisis and its management unfold. At all times, the Crisis Management Team will balance individuals' right to privacy with the overall community's need to know the facts.

The operation center for the Crisis Management Team will be the Director of College Counseling Office, located in the main building.

Find your local DCF location at https://www.mass.gov/orgs/massachusetts-department-ofchildrenfamilies/locations **Immediate assistance is available at** • Child-At-Risk Hotline 800-792-5200

More information:

The DCF has developed educational materials to provide information regarding the Warning Signs of Child Abuse and Neglect

FOR A CAMP EMERGENCY REQUIRING ASSISTANCE

All staff are authorized to call 911 without anyone's permission for a school emergency requiring the assistance, in their judgment, of police, fire, or emergency medical personnel.

The person calling for emergency assistance will:

- Call 911, stay on the line until release by the call taker
- Identify yourself, provide camp/ school name and confirm address
- Identify the nature of the situation/ incident, and location of situation
- Indicate number of victims, if any
- Provide any other relevant information
- Notify Camp Director
- Notify Camp Nurse
- Notify CMT

MEDICAL EMERGENCIES

Emergency supplies and first aid kits are stored in the health office on the first floor in the main building, the athletic training room, located in the Indoor Athletic Facility (IAF).

ON-SITE

- Staff should first take immediate action to ensure the safety of everyone involved.
- Seek medical assistance by dialing 911
- Contact the nurse

While awaiting the arrival of the nurse or other medical help:

- Follow the instructions of the nurse or other medical help you have contacted
- Keep the victim still, warm and comfortable
- Clear the area of all other campers and staff (except staff trained in First Aid/CPR)
- Make sure that a staff person will direct the nurse or other help to the scene

In the event of a medical emergency requiring a camper or campers to be removed from campus for further medical attention:

- Camp Director will designate a camp representative to accompany the camper or campers to the hospital.
- Camper health record should be provided to the attending EMTs and hospital personnel
- In the event that a larger number of campers are taken to the hospital for medical care, each camper's name, his injuries, his destination, and the time of his departure from campus will be recorded by the nurse. Any injured campers will be accompanied to the hospital by a designated camp representative.

MISSING CAMPER PROCEDURES

The staff should regularly take a count of campers for whom they are responsible, particularly when moving from one area of camp to another. If you discover a camper is missing, follow these procedures:

- Retrace the group's steps. If unsuccessful, notify the office.
- Check to see if child left camp early.
- Camp Director checks Medical Log of campers that have been sent home for medical reasons.
- Check all groups to see if camper is with the wrong group.
- Group counselors meet to determine when and where the camper was last seen. Report to the

Director.

- Camp Director remains at office to coordinate effort.
- Group staff check last known location and nearby areas.
- Specialists check all activity areas, respectively.

A thorough search is made of buildings and grounds, and if the camper is not found, then parents and police are notified. Director telephones parents to see if they have picked up the child early, made other special arrangements without notifying the Camp Office, or if the child left camp on his/her own. If the parents cannot be reached by phone, the Director will call emergency number on the medical form for information.

Parental consent must be sought before calling the Police Department. If parental consent cannot be obtained within ten minutes, the Director will notify the Police Department.

Accuracy and speed are crucial when searching for a missing camper.

CRISIS PROCEDURES

The school's Crisis Plan is reviewed regularly. Updates and revisions will be published and distributed as they occur.

A. EVACUATION PROCEDURES

In the event of a hazardous environmental condition (e.g., a fire, gas leak, etc.), campers and staff should immediately proceed with the Evacuation procedure per the guidelines below:

- The signal for an evacuation of the facility is ACTIVATION OF THE FIRE ALARM SYSTEM.
- All campers and staff must leave the building immediately and gather in designated areas, by camp group**,** in the parking lot adjacent to the main entrance to the school off of St. Theresa Avenue.
- Counselors and Junior Counselors will take attendance of campers in their particular groups, and report any absence (other than campers not in camp that day) to the camp director or his designated representative.
- Campers should remain quiet at all times.
- No one will reenter the buildings until the Camp Director (or his designated representative) gives permission to do so.

B. PROCEDURE FOR A "TAKING REFUGE" RESPONSE ON CAMPUS

In the event of a serious (but not immediate) outside threat to the safety of the school community (e.g., a military/terrorist attack on Greater Boston, hazardous weather, or direction from local law enforcement), campers, faculty, and staff should immediately proceed with the procedure per the guidelines listed below:

- The signal is REPEATED SHORT RINGS of the school bells: 2-2-2-2 and also a NOTICE VIA THE SCHOOL-WIDE PHONE INTERCOM.
- All campers and staff who are in the Jarvis Refectory, Smith Art Center, and Bauer Science Building should proceed to the Smith Theater and gather in designated areas, by group level.
- All campers and staff located in the Ernst, Gordon, Perry, or Athletic Wings, including the Indoor Athletic Facility, should proceed to Rousmaniere Hall and gather in designated areas, by group level.
- Counselors (or junior counselors) will take attendance of campers in their particular groups, and report any absence (other than campers not in camp on that day) to the Camp Director or his designated representative.
- Campers should remain quiet at all times.
- All campers and staff must remain in the assigned gathering places until the Camp Director or his designated representative gives further direction.

C. PROCEDURE FOR A "LOCK DOWN" RESPONSE ON CAMPUS

In the event of an immediate threat of violence directed at the school, campers, counselors should immediately proceed with the Lock Down procedure following the guidelines below:

- The signal for a Lock down is a 15 SECOND CONTINUOUS RINGING OF THE BELLS and also A NOTICE VIA THE SCHOOL-WIDE PHONE INTERCOM.
- When the signal sounds, all campers and staff should proceed to the nearest classroom or office.
- The classroom or office door should then be locked. An adult should be present in each occupied room.
- Campers and staff should position themselves in the room in a way that prevents their being seen through windows.
- So as not to attract attention, there should be no talking or noise-making. VI. All lights should be turned off and the shades drawn.
- A message via the school-wide intercom system may provide further instructions.
- All campers and staff must remain in place until given other directions by a law enforcement or school official.

In the event that any of the above procedures is run as practice, an intercom announcement and/or a short ring of the school bell will signal the end of the drill.

INTERNAL COMMUNICATIONS

In the event of any crisis, clear and effective communication is critical. The camp network of 2-way radios will be used to collect and share important information with staff. In the event that a radio is not accessible, school phones and personal cell phones should be used.

The CMT will oversee all internal communications with the School's constituencies regarding the facts relating to the crisis and the School's response. It will also determine the information that should be shared with the School's constituents and the timing and means of communication.

Staff and Campers

In the event that crucial information must be shared immediately with camp and school community members who are present on campus, the CMT may direct that campers and staff be assembled in the fieldhouse so that a designated staff member can provide them with any essential information. Campers and staff will be instructed by designated members to avoid speaking with the media under any circumstances and to allow the School's designated spokesperson to do so.

A designated member of the CMT or the support team will brief counselors in the Faculty Room or the Headmaster's office. He will inform those assembled of the nature of the crisis and the School's planned response, and will answer questions. He will also outline any needed follow-up steps that the counselors must take.

Parents

Parents of all campers directly involved in or affected by the emergency will be contacted by the Head of School or a designated administrator as soon as possible. The school administrator will inform parents fully of the circumstances and the School's response. In informing parents of the emergency, the administrator will consider the guidelines provided by any medical, counseling, legal, or other consultants that the School has retained to assist it in addressing the situation.

When crises arise that do not require immediate parent notification, the Head of School will provide essential information about the crisis and the School's response in a letter to parents, and, if needed, to alumni and trustees. All such communications will be prepared after consultation with any appropriate consultants to the School, including its legal counsel.

EXTERNAL COMMUNICATIONS

The Media

The CMT will determine the information to be released to the media, and may be guided in its decision making by the School's public relations consultant and/or legal counsel. An official school spokesperson – either the Head of School or his designee – will address the media and will remain available, as needed, for continued media updates.

The CMT, in consultation with the School's public relations consultant and legal counsel, will prepare any necessary press releases. All information released to the press will be consistent with that provided to the internal constituencies of the School.

The CMT will decide whether to allow the media to be on campus, given the circumstances of the particular crisis. Logistical arrangements must be immediately made with the Boston Police Department which will enforce designated perimeters for media access. In order to ensure goodwill and credibility, the School will make every effort to accommodate reasonable requests for information by the media and to provide for their effective functioning.

Any requests for camper or staff interviews by the media must be submitted to the Head of School for his approval in advance of the interview. No unauthorized information may be provided to the media.

Government Officials

The CMT will designate a spokesperson to communicate, if needed, with appropriate government officials, including town safety and government officials. No other members of the School's faculty or staff should communicate with government officials regarding the crisis.

Discipline Policy and Behavior Management Guidelines

Philosophy

At BTA Summer Camps, we abide by the Roxbury Latin school's fundamental standards. People cannot live and work together unless they agree on certain basic standards. The Roxbury Latin School is a community and Roxbury Latin Summer Programs, including BTA Summer Camp are a part of that community. To remain a member of the camp, a person must agree to and abide by certain fundamental principles:

- Honesty is expected in all dealings.
- Members and guests of this community are to be accorded respect and courtesy at all times.
- Diligent use of one's talents is an expected commitment in all school endeavors.
- Private and public property are to be treated with care and with respect.

While the school's standards are primarily applicable to the conduct of students while they are at school or participating in school-sponsored activities, the summer programs expects campers to live by these standards at all times. Providing supports that benefit all campers such as adequate structure, clear expectations, good modeling, and positive reinforcement, we strive to create the optimum conditions for campers to fully and appropriately participate in camp activities. We recognize, however, that every child is unique and some require additional supports to be successful.

Within the bounds of maintaining a safe camp community, we are committed to making every effort to meet the needs of all campers.

Specifically, BTA Summer staff are expected to:

- Act as role models—everywhere, not just during camp sessions or on location. Campers learn from us (for better or for worse) wherever we have contact with them. How we act in every situation will be noticed.
- Strive to keep expectations of children developmentally and physically appropriate while keeping in mind the children's dignity and self respect.
- Establish a group atmosphere that is non-punitive in nature and where comments focus on reinforcing children's appropriate behaviors rather than commenting on negative behaviors.

- Comment on behaviors in constructive ways and suggest appropriate alternative behaviors.
- Encourage children to be responsible for their own behaviors.
- Recognize that each new day brings a fresh start for each camper.

Fairness

BTA Summer Camps will determine and review the facts of the case, establish responsibility, and establish a method of dealing with the person(s) involved. We reserve the right to maintain the integrity and credibility of the Roxbury Latin school's standards and the long- and short-range welfare of the whole camp community, and serve the well-being of the camper(s); their ability to deal with reality, their

Staff Responsibility

While it is important for campers to be responsible for their own behavior, a greater responsibility rests with staff in determining how to maximize camper support. If one strategy doesn't work today, what can be tried differently tomorrow? If a behavior happened in a certain situation today, how can we avoid that situation tomorrow?

Discipline Policy

Depending on the situation, staff should take the following steps in an effort to address unacceptable behavior and correct the situation. BTA Summer Camps reserves the right to skip any the steps if the situation warrants.

1. Staff will redirect the child to more appropriate behavior.
2. Tphlea cceh.i lTdh wisi lml bues tr ebme dinodneed i no fa t hpeo sbietihvaev mioarn gnueird ealninde, iafn p eyesight) of other campers.
3. In the event of continuing or more severe misbehavior, staff will document the situation using a Camper Log held by the Camp Director. This written documentation will include what the behavior problem is, what provoked the problem, and the corrective action taken.

The Camper Log will remain in the possession of the Camp Director after a counselor has written the log.

1. If the behavior persists, a parent will be notified (by phone or in person) of the problem by the camper's Head Counselor. The Camp Director will be responsible for placing the call home.
2. Pick-up and drop-off are generally not appropriate times for this type of communication with parents.
3. If warranted, the camp director will schedule a conference with the parent so they can determine the appropriate action to take.
4. The Camp Director and counselors involved will follow the plan set forth in the conference and continue to monitor the camper's progress. The Head Counselor should keep the Camp Director informed of the camper's progress.
5. If the problem still persists, the Head Counselor will schedule a conference that includes the parent, child (if appropriate), staff and Camp Director. The Camp Director will have all documentation to date and the notes from any previous conferences for review.
6. If a child's behavior at any time threatens the immediate safety of that child, other children or counselors, the parent may be notified and expected to pick up the child immediately.

7. If a problem persists and the child continues to disrupt the program, BTA Summer Camp reserves the right to dismiss the child from the program. Decisions regarding dismissal shall be made in conjunction with the Camp Director.

At NO TIME is it acceptable for staff to use the following forms of discipline:

- Spanking or other corporal punishment
- Utilizing cruel or severe punishment including humiliation, intimidation, verbal or physical abuse or neglect
- Depriving children of meals or snacks
- Disciplining a child for soiling or wetting clothes
- Lying to children or promising what cannot be delivered
- Labeling children and using such labels in a wrongful manner
- Breaking confidentiality by talking about children or their families inappropriately in front of another person
- Assigning group discipline due to one misbehaving child

EMERGENCY TREATMENT PROTOCOLS / STANDING ORDERS

Wound Care / Bleeding / Burns

Burns should be run under cold water for 15-20 minutes. Protect with sterile dressing. Severe burns or those over large areas of the body should be covered with sterile dressings and referred via 911 for emergency medical treatment.

For superficial abrasions, cuts, open blisters and the like, clean with soap and water and apply antibiotic ointment and clean dressing.

For bleeding wounds or deep lacerations – apply pressure until bleeding controlled, apply clean dressing, call parent and arrange for further medical treatment.

For severe bleeding, apply pressure with sterile dressings, provide supportive care and call 911 for hospital transport.

Superficial foreign bodies can be removed with tweezers from soft tissues. Eyes should be rinsed with water for suspected surface foreign body/dust or exposure.

If there is an impaled or deeply embedded foreign body present in any body part, do not attempt to remove the foreign body. Cover area with sterile or clean bandages and refer for emergency medical care. In the case of a deep foreign body in the eye --- both eyes should be covered/bandaged.

Allergic Reactions

For mild to moderate and local skin reactions – apply cool compresses and/or 1% hydrocortisone cream. Benedryl may be given po as per standing orders below as necessary.

For severe reactions and/or any systemic symptoms of anaphylaxis/generalized urticaria/respiratory distress – follow EpiPen use protocol, call 911 for immediate emergency medical care while providing supportive care.

Asthma / Respiratory Distress

Follow individual care plan for those children who have been previously diagnosed. For children with no prior history may provide one albuterol treatment either as unit dose vial via nebulizer or as two (2) puffs of albuterol inhaler with spacer device. Monitor vital signs for improvement.

Any previously undiagnosed child with respiratory symptoms requiring treatment or any known patient who does not respond to treatment must be referred for further medical evaluation. 911 should be called for any child with severe distress, no response to treatment, or question of obstructed airway/inhaled foreign body.

Abdominal Pain/Vomiting/Diarrhea

If no improvement after ¼ - ½ hour observation, and/or if not tolerating clear fluids, parents should be contacted and child should be sent home from camp for further medical evaluation as necessary. Children with recurrent vomiting/diarrhea should be sent home and should not return to camp until symptoms free for 24 hours.

For severe, acute abdominal pain, check all vital signs, maintain child NPO, do not treat with oral medications and refer for further medical treatment (either via parents or by ambulance if necessary).

Fever/Infectious Disease

Fever is defined as an oral temperature greater than 100.4 degrees. Tylenol or Motrin may be dispensed as per standing orders below. Children should be sent home from camp and excluded from returning until afebrile for 24 hours.

Any child with an infectious disease that requires treatment with oral or topical antibiotics (e.g. strep, infectious conjunctivitis, impetigo, etc) should be excluded from attending camp until a minimum of 24 hours of antibiotic treatment has passed.

Any child with other contagious infectious disease (e.g. varicella, 5th disease) should be excluded from camp activities until contagion risk is over as advised by child's PCP and camp health director.

Parents of other campers in groups exposed to contagious illness (e.g strep, 5th disease, varicella) should be notified of the exposure by letter from the camp nurse.

Diabetic Crisis/ Hypo or Hyperglycemia

Follow individual care plan for those children so diagnosed.

Camp nurse may check capillary blood sugar levels if question of altered mental status, syncope, dehydration, etc.

Hypoglycemia is defined as blood sugar <70 – give juice, sugar containing beverage orally if mental status intact.

Hyperglycemia is defined as blood sugar > 180 – encourage fluids, contact parent and seek further medical care.

A depressed level of consciousness/altered mental status requires emergency medical treatment by calling 911

Traumatic Injuries

Any head injury resulting in altered or loss of consciousness requires emergency medical treatment by calling 911. Children with minor head injuries should be observed for a minimum of 15 – 30 minutes for any change in status or other symptoms (vision changes, amnesia, lethargy, speech changes, vomiting, severe headache). If other symptoms develop, child needs to be referred for medical evaluation.

Children sustaining injuries with any complaints of abdominal pain or vomiting should be evaluated and observed by the camp nurse as per the abdominal pain protocol above. Any question of worsening abdominal pain, recurrent vomiting, altered vital signs, or any incidence of multiple trauma (e.g. head and abdomen) must be sent for emergency medical treatment by calling 911.

For strains and sprains ice should be applied, ace bandage can be used for support, and Tylenol or Motrin can be administered per standing orders below. If child has decreased use of extremity (e.g. pain with ambulation), parent should be contacted and child brought for further medical evaluation.

For any suspected bone fractures, area should be immobilized, if possible by splint in a position of comfort. No attempt should be made to correct any noticeable deformities. Elevate area if possible. Maintain child NPO. Call 911 for emergency medical treatment.

Heat Illness

Assess vital signs. Rest in cool area. Encourage oral fluid intake in small amounts over 1 hour, if able to tolerate. Apply cool compresses as necessary. For any signs of shock, altered mental status, recurrent vomiting refer for emergency medical care by calling 911. If tolerating po fluids, contact parents and send home with advice for medical evaluation.

Approved Medications – Standing Orders

1. Acetaminophen

Indications: minor pain, fever, headache

Contraindications/Precautions: known allergy or sensitivity, need for patient to be NPO

Dosage: 10-15mg/kg/dose by mouth every 4-6 hours as needed. (maximum dose: 500mg)

1. Ibuprofen

Indications: menstrual cramps, musculoskeletal pain, higher fevers not responsive to acetaminophen

Contraindications/Precautions: pregnancy, known allergy or sensitivity to

NSAIDS or Aspirin, need for patient to be NPO, can cause GI upset on empty stomach. Dosage:
10mg/kg/dose every 6-8 hours as needed (maximum dose: 400 mg unless otherwise prescribed by physician)

1. Diphenhydramine

Indications: antihistamine – urticaria, mild/local allergic reactions, moderate allergic reactions, pruritis

Contraindications/Precautions: known allergy or sensitivity, can cause sleepiness – should not be taken if driving, operating machinery, or otherwise
responsible for monitoring other individuals

Dosage: 1mg/kg/dose every 6 hours as needed (maximum dose: 50mg for adults)

1. Albuterol

Indications: bronchospasm, wheezing, asthma

Contraindications: known sensitivity or allergy, cardiac disease/arrhythmia – may speed up heart rate

Dosage: 2 inhalations from MDI with spacer device/dose. Usual every 4-6 hours. May give up to ½ - 1 hour apart in emergency situation

1. Epi – Pens (Epinephrine) Please see Epi-Pen protocol.

1. 1% Hydrocortisone

Indications: local pruritis, local allergic reaction, dermatitis Contraindications/Precautions: known sensitivity or allergy
Dosage: apply topically to affected area 2-3 times/day. Should not be used under occlusive dressing

1. Topical Antibiotic Cream

Indications: superficial wound care Contraindications/Precautions: known sensitivity or allergy Dosage: apply topically to affected area 2-3 times/day.

Seasonal and Long Term Record Keeping

The First Aid Log is a bound, pre-numbered book used for recording first aid encounters. It remains in the Camp Director all summer. In off-season, the First Aid Log is kept in the Camp Director's office. Medication Administration Log is maintained by the nurses in the Health Office.

2024 Camp Changes

Definitions: Aquatic Activity has now been defined.

Concussion training is now written as needed to be completed **annually.**

430.103: Supervision and Operation of Specialized High-Risk Activities All onsite aquatic activities at your camp shall now have an aquatics director.

Watercraft:

- For every 25 campers participating in watercraft activity, or portion thereof, one counselor shall be a lifeguard.
- Each counselor operating or supervising watercraft activities shall have documented in-person participatory training specific to watercraft activities being overseen.
- Training requirements for paddle sport activities (canoe, kayak, paddleboard, etc.)o Each counselor shall hold a lifeguard certification or hold certifications in American Red Cross Basic Water Rescue and EITHER American Red Cross Small Craft Safety or the American Canoe Association Paddle Sports course, or equivalent cert. recognized in writing by the Department that demonstrates water rescue procedures specific to the type of water and activities conducted.

- Training requirements for each counselor operating or supervising sailing or motor-powered watercraft activities:

o Obtain a Boater Safety Education Certificate issued by the Commonwealth of

Massachusetts or an equivalent recognized in writing by the Department AND comply will all Federal and Massachusetts Boating Laws including M.G.L. c. 90B 323 CMR 2: *The Use of Vessels,* and 323 CMR 4.00: *The Operation of Personal Watercraft.*

- Sailing and Motor-powered watercraft activities shall not be conducted in hazardous salt or freshwater conditions.
- Each conducting watercraft activities shall develop a written boating safety plan, in consultation with the Aquatics Director. Plan shall include procedures for emergencies on the water and unexpected hazardous water conditions.

430.145: Maintenance of Records:

- Operators shall be responsible for destruction of records in a manner that protects privacy of all campers, staff and volunteers. CORI's must be destroyed in accordance with 803 CMR 2.15.

(NOTE: this is after keeping records for a min of 3 years).

430.154: Injury and Incident Reports

- An online report shall be generated for each fatality, serious injury or incident that results in camper or staff being sent home, brought to the hospital, or treated by a health care provider where a positive diagnosis is made.
- Sent report to the DPH AND the Natick Board of Health as soon as possible but no later than 7 days from the injury/incident.
- Such injuries or incidents shall include but not limited to, cuts/lacerations where stiches are needed, resuscitation or other life saving measures, fracture/dislocation, concussion,

administration of epi-pen, resulting errors in the administration of medications including diabetes care.

- The health care provider or camp director shall comply with all application reporting requirements of M.G.L c. 94C as well as 105 CMR 700.000 *Implementation of MGL c. 94C*, including reporting any medication given in a manner that is inconsistent with the individual's prescription or violation of 105 CMR 700.000. This shall be reported to DPH and Natick BOH within 7 calendar days of incident.
- Any administration of glucagon shall be considered a serious injury and must also be reported.

430.160(E): Policy on Administration of Medication:

- Training of unlicensed HCS by HCC must include content standards and tests of competency approved by the department for diabetes medications, oral and topical medications (forms can be found on our website as well as State website)
- Your policy and procedures shall include a section on the administration of medications at the camp. Your policy shall list your health care consultant(s) or health care supervisor(s) who are authorized to give medications, epi-pens and medications for diabetes per the Health Care Consultant.
- Policy on Epi-pens and medications for Diabetes Care: o A camper may self-administer and possess an epi-pen IF the HCC and parent/guardian has given written approval
  - A camper may receive an epi pen injection by HCC, HCS, or any other camp staff IF the HCC and parent/guardian has given written approval and the HCS or other camp staff has received training from the HCC.
  - Blood sugar monitoring and medication administration for Diabetes can be done by the camper if the HCC and parent/guardian has given written approval and it takes place in the presence of a HCS. o Diabetes care can be done by a HCS if the HCC and parent/guardian have given written informed consent.
  - Inhalers: a camper may possess and self-administer an inhaler if they are capable of doing so and have written approval from HCC and parent/guardian.

430.204: Waterfront and Boating Program Requirements:

No watercraft shall be allowed in the swimming area unless in accordance with Massachusetts Boating Laws and operated by lifeguards on waterfront duty with permission of the aquatics director or camp director.

430.210 (E): Plans Required to Deal with Natural Disasters or Other Emergencies

• In addition to Traffic control, Lost camper Plan, etc. you must now include a Disease Outbreak Response Plan (including but not limited to, alternative staffing plans, isolation and quarantine space, and disease reporting requirements).

430.372: Hygiene Supplies at Toilet and Handwashing

• Handwashing sink (station) is required. Day camps is 1 sink per 30 campers.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Environmental Health Community Sanitation Program

250 Washington Street, Boston, MA 02108-4619
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Reducing Risk of Mosquito-borne Illness While Outdoors
Guidance for School Staff: Applying EPA- Approved Mosquito Repellent to Prevent EEE

2021 is likely to be the third year of an EEE outbreak cycle in Massachuse s, and there will probably be some risk to people. However, children can con nue to spend me outdoors for recess and other ac vi es during the day with the use of repellent—as well as wearing long-sleeves, long pants, and socks when possible. Outdoor ac vi es should be avoided between dusk and dawn, when mosquitoes are most ac ve.

EEE (Eastern equine encephali s) is a rare but serious disease that is generally spread to people through the bite of an infected mosquito. **EEE can cause severe illness and possibly lead to death** in any age group; however, **people under age 15 are at par cular risk.**

To reduce the chance of becoming infected, the Department of Public Health (DPH) recommends always applying an EPA-approved mosquito repellent to children before they go outside. EPA approved repellents contain DEET, permethrin, picaridin, or oil of lemon eucalyptus

Please note the following within the context of a school se ng:

- Because repellants are not considered a drug or medication, they are not subject to 105 CMR 210, and thus schools are *not* limited to only those school staff who are designated by the school nurse as staff authorized to administer medications. Schools should identify staff that can:
  - follow the procedures laid out in these guidelines
  - read and understand the application instructions listed on the repellent o communicate with students, and o monitor a student to identify adverse effects, such as a rash.
- Staff should wash their hands before and after each application (do not wear gloves).
- Parents/Caregivers should be notified of any school-supplied repellent and be given the option to opt out of having repellent applied to their child.
- Parents/Caregivers can provide their own repellent to be applied to their child, however, Parents/Caregivers need to communicate with the school in regards to any repellent being sent in for their child, so that school staff may label and safely secure the repellent.
- Follow safe storage guidelines; school should store insect repellents safely out of the reach of children, such as in a locked cabinet out of the reach of small children.

Using Repellents Safely

- *DEET* products should not be used on infants under two months of age and should be used in concentrations of 30% or less on older children. *Oil of lemon eucalyptus* should not be used on children under three years of age. *Permethrin* products are intended for use on items such as clothing, shoes, bed nets and camping gear and should not be applied to skin.
- Follow the instruc ons on the product label. If you have ques ons a er reading the label, such as how many hours does the product work for, or if and how o en it should be reapplied, contact the manufacturer.
- **Don't let children handle the product.**
- To apply, put some on your hands first and then apply it to the child's arms, legs, neck and face.
-
- Don't use repellents near the mouth or eyes and use them sparingly around the ears.
-
- Be sure not to put any repellent on the child's hands.
- Don't apply any repellant underneath the child's clothing or facemasks.
- Don't use repellents on any cuts or irritated skin.

Use just enough product to lightly cover exposed skin and/or clothing. Pu ng on a larger amount does not make the product work any be er.
If a rash or other symptoms develop and may have been caused by using a repellent**,** stop using the product, wash the affected area with soap and water, and contact a health care provider or local poison control center. If there is a visit to the doctor, send the product with the child.

Authorization to Administer Medication to a Camper

(completed by parent/guardian)

Camper and Parent/Guardian Information	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	
Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:
Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	

Special Precautions:
Possible Side Effects/Adverse Reactions:
Other medications (at parent/guardian discretion):
Location where medication administration will occur:
Medication Information 2
Name of Medication:

Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:

Expiration date of Medication Received:
Special Storage Requirements:
Special Directions (e.g., on empty stomach/with water):
Special Precautions:
Possible Side Effects/Adverse Reactions:
Other medications (at parent/guardian discretion):
Location where medication administration will occur:
Authorization Information
I hereby authorize the health care consultant or properly trained health care supervisor at _____

(name of camp) to administer, to my child, _____ the medication(s) listed above, in accordance with 105

CMR

If above listed medication includes epinephrine injection system:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer

☐ Yes ☐ No ☐ Not Applicable

If above listed medication includes insulin for diabetic management:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

Signature of Parent/Guardian:	Date:

** **Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

105 CMR 430 References

105 CMR 430.160(A): Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for

105 CMR 430.160(C): Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for

campers brought from home shall only **105 CMR 430.160(D):** A written policy for the administration of medications at the camp shall identify the be administered if it is from the original container, and there is written individuals who will administer medications. This policy shall:

1. List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.
2. Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.
3. Document the circumstances in which a camper, Heath Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or preexisting medical condition may:

a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:

1. the camper is capable of self-administration; and
2. the health care consultant and camper's parent/guardian have given written approval

b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:
1) the health care consultant and camper's parent/guardian have given written approval; and 2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.

(4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the

camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor **105 CMR 430.160(F):** The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

105 CMR 430.160(I): When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:

1. Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.
2. The medication disposal log shall be maintained for at least three years following the date of the last entry.

Disease Outbreak Response Plan

Identification

- Screen new camper/staff as they arrive at camp for any current or resent illness. Any symptomatic campers or staff members should be referred for medical evaluation.
- Check the medical log entries daily for common ailments and/or increased frequency of cases of illness with similar symptoms (i.e., headache, vomiting, diarrhea, fever, eye infection, sore throat, etc.).

If multiple campers and/or staff are ill, contact your local health department immediately (remember, reporting is required within 24 hours). Your children's camp may be experiencing a food, water, or person-to-person transmitted outbreak.

In the event of an outbreak, develop and maintain a log/line list of ill campers and staff. This list should include the name, age, sex, camper or staff, unit/dorm/tent/cabin, onset date/time, symptoms, duration (hours), specimens collected, treatment/action (treatment provided, went home, etc.), job duties (for staff). A sample log/list is included in this document.

Depending on the situation, the local public health department may recommend collec ng stool or vomitus specimens from ill campers and staff for laboratory testing to try to determine the organism causing the illness.

Prevention and Control

- Handwashing (staff and campers) must occur frequently and not just during outbreaks! o Adequate supplies of hand washing soap and disposable towels must be available at all times in food service and dining areas, bathrooms, and other areas where toileting or food service may occur.

o Wash hands carefully with soap and warm, running water for 20 seconds after using the toilet.

Additionally, all campers and staff should wash their hands frequently throughout the day and before eating or preparing food. Staff should monitor campers' handwashing. Camp staff should supervise and/or help young children wash their hands thoroughly and properly. o Hands should be washed with soap and warm water prior to performing ceremonial hand washing (e.g., *Asher Yatzar or Netilat Yadayim*). o Alcoholbased hand sanitizers should be used if soap and water is not available. Consider making alcohol-based hand sanitizers available throughout the camp.

    - Exercise caution and ensure proper supervision of young children using alcohol-based sanitizers.
    - When hands are visibly soiled, after toileting, and after cleaning vomitus or other potentially contaminated body fluids, alcoholbased sanitizers should not substitute for soap and water when possible.
- Housekeeping - "Sick" areas (bathrooms, sleeping areas, etc.) and high touch surfaces require increased housekeeping emphasis. o Conduct regular cleaning and disinfection of bathroom facilities and high touch surfaces, toys, sports equipment, table tops, faucets, door handles, computer keyboards and the handles of communal washing cups.

Disinfection can be accomplished with chlorine bleach (at a recommended concentration of 1 part household bleach to 50 parts water) to be used to disinfect hard, non-porous environmental surfaces. o Staff should be educated on and wear personal protective equipment (gloves and masks) and use disposable cleaning products when cleaning vomitus. In addition, staff should practice thorough handwashing, and be encouraged to change to clean clothing prior to resuming other activities.o

Mdo isaHitnatrfneedsclstee cdlion overen rdssi,s sscolaeirleedpdei dnw.g it hb avgosm, iatunsd ocrlo ftehci little as possible. These items should be laundered with detergent in hot water (at least 140°F) at the maximum cycle length and then machine dried on the highest heat setting. If there are no laundry facilities onsite capable of reaching 140°F, soiled items should be double bagged (using plastic bags) and taken offsite for proper washing and drying. If soiled items are sent home, instruct parents or caregivers of the proper washing and drying procedures.

- Water Supply - Ensure proper treatment and only use approved sources.
- Food Service o Always exclude ill food handlers from work and use gloves or utensils to handle prepared and ready to eat foods, including drink ice (not just during outbreaks). o Ensure that all food service staff (including campers who occasionally handle foods) wash their hands thoroughly before food handling and immediately after toilet visits.
    - Discontinue salad and sandwich bars, "family-style" service, buffets - use

servers only. o Dining areas, including tables, should be wiped down after each use using a bleach solution of 1 part household bleach per 50 parts waters. If a person vomits or has a fecal accident in 3 the dining hall, clean the affected area immediately. Food contact surfaces and dining tables near the accident should be sprayed using a bleach solution of 1 part household bleach per 10 parts waters. Allow surfaces to air dry. Food that was in the area when the accident occurred should be thrown away.

    - Don't allow use of common or unclean eating utensils, drinking cups, etc.o Require cleaning

      staff/dishwashers to observe sanitary precautions.

Restrictions and Exclusions

- Physically separate ill from well campers and staff.

o at day camps, ill campers or staff members must be immediately isolated at the camp's infirmary or holding area and arrangements made to send them home. o at overnight camps, campers or staff members must be isolated from other campers in the infirmary or a location separate from uninfected campers and staff. Depending on the camp context and duration, camp directors may want to consider sending home campers and staff with illness or closing the camp.

- Exclude ill persons from duties and/or activities until permission is granted by the health director to resume.
- Restrictions from activities and isolation periods for ill individuals vary based on the type of illness. Consult your local health department for the appropriate length of time period of isolation and activity restrictions for ill individuals to effectively prevent the spread of the illness throughout the camp.

- Any camper and staff who are sent home should seek prompt medical attention.
- New arrivals should not be housed with sick or recovering campers and staff.
- Limit entry/exit from camp; postpone or restrict activities involving visitors, including other camps.

Reporting and Notification

- Camps are required to notify their local health department within 24 hours of illnesses suspected of being water, food, or air-borne, or spread by contact. Local and state health departments are available to consult on prevention and control of any case or outbreak of illness in a camp.
- Notify parents of the illness outbreaks. Please contact your local health department for assistance or template letters that can be used.

Questions or comments: bcehfp@health.ny.gov

Revised: July 2018

Inspection Form

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN (STATE SANITARY CODE, CHAPTER IV)

Agency Name **Agency Address**

Phone Number

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

Camp Name and Location Information		
Camp Name:		
Location where camp operates:		
City:	State: Massachusetts	ZIP Code:
Phone:	Fax:	
Email:		
Camp Owner/Organization Information		
Owner/Organization Name:		
Phone (year-round):	Email:	
Camp Director/Operator Information (if different than owner)		
Director/Operator Name:		
Phone (year-round):	Email:	

Type of Camp:

☐ Residential	☐ Day	☐ Sports	☐ Other (specify):
☐ Travel/Trip	☐ Primitive	☐ Medical Specialty	_____

Camp Capacity:

Expected Number of Staff per Season: _____

Expected Number of Volunteers per Season: _____

Expected Number of Campers per Season: _____

Dates of Operation:

Number of sessions per season: _____ Hours of operation: _____

Session Date(s):

Inspection Information	
Inspection Date:	Reinspection Date (if applicable):
Inspection Conducted By:	
Accompanied During the Inspection By:	
Operator demonstrated compliance with 105 CMR 430.000. License will be issued.	
2024 License Number:_____	
☐ Operator was unable to demonstrated compliance with 105 CMR 430.000. License will not be issued.	
Inspector Signature:	

Inspection Form

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

This form can be used to document areas of compliance or violations of 105 CMR 430.000 Minimum Standards for Recreational Camps for Children. This form should be completed in its entirety. Additional comments or details of a violation may be added to the end of this form.

"**No**" column = ✓ marked below indicates a violation of 430.000 "**Yes**" column = ✓ marked below indicates compliance with the provision of 430.000 "**N/A**" column = ✓

marked below indicates the provision of 430.000 is not applicable to this

camp

Regulation – 105 CMR 430.000		Yes	No	N/A	Comments
Current license to operate a Recreational **.050** Camp for Children from the Local Board of Health (LBOH)					
PERMITS/APPROVALS					
.451	Current certificate(s) of inspection from local building inspector for all sleeping or assembly areas				
.215	Written compliance from local fire department				
.300(A)(2)(a)	**Private water supply:** DEP approval (>25 people, >60 days/yr)				
.300(A)(2)(b)	**Private water supply:** (<25 people OR <60days/yr)				
	BOH approval, chemical & bacterial analyses, no more than 45 days prior to opening				
BACKGROUND INFORMATION AND ORIENTATION REQUIREMENTS					
.090(A)	Written procedures for review of background information of Staff and Volunteers				
.090(C)	**Staff** • CORI and SORI reports available/stored securely • Previous work history (minimum 5 years) • 3 positive reference checks (no relatives) • Out-of-state/International criminal background checks available (as needed)				# CORI Viewed_____ # SORI Viewed_____

.090(D)	**Volunteer(s)** • CORI and SORI reports available/stored securely • Previous work/volunteer history (minimum 5 years) • Out-of-state/International criminal background checks available (as needed)				# CORI Viewed_____ # SORI Viewed_____
.090(F)	All Background Information - Received, reviewed, and determination for employment made pursuant to 105 CMR 430.090(C&D)				
.091 **.210**	**Staff/Volunteer Orientation**: Detailed Orientation Plan with attendance records, specialized trainings, training on Disaster/Emergency Plans, Health Care and Infection Control Policies, and annual concussion awareness training				Date(s) of Orientation:_____

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

CAMP POLICIES - WRITTEN					
.093	Abuse and Neglect Prevention Policies and Procedures Reporting procedures in accordance with M.G.L. c. 119 § 51A				

	Written notification to MDPH and LBOH if 51A report is filed with DCF				

.190(B)	Camper released only to Parents/Guardians or: • Designated individual with Parent/Guardian authorization (electronic or hard copy form) • Authorized alternative arrangements				
.190(D)	Protocol to handle unrecognized persons at camp				
.191	Discipline Policy: Identify appropriate discipline methods and list the Prohibitions (exactly as stated below): 1. Corporal Punishment, including spanking, is prohibited 2. No camper shall be subjected to cruel or severe punishment, humiliation, or verbal abuse 3. No camper shall be denied food, water, or shelter 4. No child shall be punished for soiling, wetting or not using the toilet				
.210(A)	Fire Evacuation Plan and Drills: Plan indicates fire drills held within the first 24 hours of each session				
.210(B)	Disaster/Emergency Plan				
.210(C)	Lost Camper Plan / Lost Swimmer Plan				
.210(D)	Traffic Control Plan				
.210(E)	Disease Outbreak Response Plan				
.163	Sunscreen policy with parent/guardian sign off				
DAY CAMPS - SPECIAL CONTINGENCY PLANS					
.211(A)	Camper doesn't show up for day				
.211(B)	Camper doesn't show up at point of pick up				
.211(C)	Child not registered arrives				
PROMOTIONAL LITERATURE/GENERAL REQUIREMENTS					
.157(C)	Meningococcal Disease & Immunization information provided to Parents/Guardians annually				
.157(D)	Policies Provided to Parents/Guardians:				
	Care of Mildly Ill Campers, Administration of Medications and Emergency Health Care Provisions				
.157(E) **(at time of** applica on**)**	Inform parents of their right to review Background Check, Health Care, Discipline Policies, and grievance procedures upon request				
.190(C)	Regulatory compliance and licensing statement on all promotional literature/advertisements: "This camp must comply with regulations of the MDPH and be licensed by the LBOH."				

FIELD TRIPS					
.212(A)	Written itinerary provided to Parents/Guardians and means to notify Parents/Guardians of changes to itinerary before departure				
.212(B)	Minimum 1 health care supervisor (HCS) accompanying field trip and for travel/trip/primitive camps the source of emergency care identified				
.212(C)	Health records and medications readily accessible for all campers/staff and First Aid kit present				
.212(D)	Written contingency plans for all field trips (Natural disasters, lost camper/swimmer, injuries and illnesses)				
TRANSPORTATION					
.250	Vehicles comply with M.G.L. c. 90 §§ 7B & 7D: • <14 passengers & driver is camp coach, director, etc. camp vehicles may be used • >14 passengers, vehicle must be school bus • RMV compliant w/ annual safety inspection				
.251(C)	Seatbelts must be worn				
.251(D)(E)	1 transpo voluntee r required when the pickup/drop-off Campers site 8+ mpers under 5 yrs. of age				
	2+ campers with physical handicaps				
	Camper under the age of 7 are not transported				

.251(I)	longer than 1 hour non-stop				
.252	*Camp vehicle drivers: 18 yrs.+, 2+ yrs. driving experience, current license for type of vehicle, and First Aid certified if no other trained staff aboard*				
.253	*Proper automobile insurance*				
STAFF QUALIFICATIONS					
Camp Director Requirements					
.102(A)	**Residential:** 25 yrs.+, complete a Camp Administration Course or 2+ seasons experience				
.102(B)	**Day**: 21 yrs.+, complete a Camp Administration Course or 2+ seasons experience				
.102(C)	**Primitive, Travel, Trip**: 25 yrs.+ and proof of experience supervising children in similar activities				
.102(D)	**Designated Substitute:**				
Counselors/Junior Counselors:					
.100(C)(2) **.100(A)(B)**	**Day Camp, Non-Sport**: *Counselor*= 16 yrs.+ OR *Junior* Counselor=15 yrs.+ ▫ 4+ weeks experience and attend orientation/required training(s)				
.100(C)(1) **.100(A)(B)**	**Residential, Primitive, Sport, Travel, Trip, Medical Specialty Camp:** *Counselors* = 18 yrs.+ or graduated from high school OR *Junior Counselors* = 16 yrs.+ ▫ 4+ weeks experience and attend orientation/required training(s)				

Required Ratio of Counselors to Campers:					
.100(C)(3)	All counselors 3 yrs. older than campers				
.101(A)	**Residential / Day / Sports Camps**: 1 counselor per 10 campers 7 yrs.+ 1 counselor per 5 campers under 7 yrs. Jr. counselors supervise 50% of counselor ratio and always under direct supervision of counselor				
.101(B) **.159(C)**	**Primitive / Travel / Trip Camps**: 1 counselor per 10 campers				

	• 1 counselor 21 yrs.+ • 2 counselors minimum with 1 counselor having a CPR and First Aid Certificate				
.101(A)(B) .103	**All Camps:** Staffing plan to supervise campers with disabilities during regular and specialized high-risk activities				
MEDICAL PERSONNEL					
HEALTH CARE CONSULTANT (HCC)		Name: License #:			
.020 **.159(A)**	**MD/DO NP** **PA** **Check for Annual Health Car* *Consultant* *Agreement**				
.159(A) (15)	Assists in the development, review, and approval of the Health Care Policy/First Aid training of staff, and is available for consultation at all times				
.159(A)(6)	Develop written orders to be followed by HCS, including responsibilities for medication administration				
.160(C)	Acknowledge in writing a list of all medications administered at camp				
.160 **(I)(J)**	*Develop/provide trainings and tests of competency for:* HCS on prescription medication administration HCS and other staff on administering Epinephrine AutoInjectors Unlicensed individuals authorized to administer medications for diabetes care only at medical specialty camps Unlicensed HCS on the signs and symptoms of hypo- and hyperglycemia and appropriate diabetic plan management (no test required)				
HEALTH CARE SUPERVISOR (HCS) (Must have at least 1 HCS on site at all times)		Name(s): License # (if applicable):			
.020 .159(C)(E)	*Nwith CPR/First Aid* *MD PA NP RN LP* *yrs.+, with First* *certificate certificate8* *Aid/CPR*				
.160(I)	Documentation of completed required trainings for unlicensed HCS:				

	• Prescription medication administration • Administering Epinephrine Auto- Injectors • Signs/symptoms of hypo- and hyperglycemia and appropriate diabetic plan management				
Health Care Training for Other Camp Staff					
.160(I)(2)	Documentation of completed required training and test of competency for othe camp staff designated to administe r Epinephrine Auto-Injectors				
.160(I)(4)	**Medical Specialty Camps Only:** Documentation of complete required training and test of competency for unlicensed individuals authorized under 105 CMR 430.159(F) to administe r medications for diabetes care				
MEDICAL POLICIES AND FACILITIES					
.159(B)	Written Camp Health Care Policy				
.160 (A)(B)	*ALL medications stored in original containers and kept in a secure manner. Refrigerated medications stored at temperatures of 36°F - 46°F*				
.160(C)(E) (F)(G)	*Written Medication Administration Policy:* • List HCS authorized to administer medications, individuals authorized to administer Epinephrine AutoInjectors, and individuals authorized to administer medications for diabetes care pursuant to 105 CMR 430.159(F) • Training requirements • Obtain written Parent/Guardian permission or informed consent for medication(s) to be administered to minors				
.160(D)	**Medical Specialty Camps Only:** Administration of medication for diabetes care conducted under the direct supervision of a healthcare provided listed in 105 CMR 430.159(E) and maintain registration pursuant to M.G.L c 94C, s. 9				

.155	Medical Log is readily available, signed by authorized staff and includes all health complaints, treatments, and medication administration errors				
.160(K)	All medications returned to Parents/Guardians or properly disposed of and documented in disposal log				
.154	and Incident Report(s) completed or Injury a . atality, seriou tion adminis copy sent to MDPH & LBOH				
.161(A)(B) .453	*Day / Residential Camps - Infirmary* *provided with adequate lighting* **Residential Camps** - Easily recognizable and accessible during the day and night. Isolation area for a sick child with the ability to provide negative pressure				
.161(C)	*First Aid Kit: meet ANSI Z308.1-2015 standards* Minimum: 1 Class B kit and 1 Class A kit				
.140 **.160 (L)**	Medical/Biological waste managed in accordance with 105 CMR 480.000				
HEALTH/MEDICAL RECORDS					
.150 **.160(C)(G)(H)F)**	*Health Records for Campers & Staff:* **Staff/Campers under 18 yrs.**: • Address, Parent/Guardian and Health Care Provider contact information • Authorization for medication administration, emergency care, and self-administration of epipens/insulin/inhalers • Injury/Incident Reports **Staff/Volunteers 18 yrs.+:** Authorization for emergency care				
.151(A)	*Residential, Travel, Sports, or Trip Camp:* • Medical history signed by health care provider • Physical within 18 months				
.151(B)	*Day Camp: Medical history signed by* *Parent/Guardian or health care provider*				

IMMUNIZATIONS					
.152	Campers/Staff under 18 yrs. **Refer to annual memo*				Number of Records Checked: _____
.152	Staff 18 yrs.+ **Refer to annual memo*				Number of Records Checked: _____
.153	Exemption Documentation				
	CAMP ACTIVITES				
.190(A)	Activities and physical environment meet the needs of campers, not a hazard to health/safety				
.205	Craft equipment in good repair, of safe design, properly installed with safety precautions taken				
.206	Playground equipment properly maintained: • Fields/surfaces free of holes/accident hazards • No concrete under/around securely anchored playground equipment • Pliable or canvas swing seats				
	SPECIALIZED HIGH RISK ACTIVITIES				
.103	Confirmation that specialized high risk activities conducted outside of MA comply with all laws/regulations for such activities in the state/local jurisdiction where the activity is held, including required licenses/permits				
Supervision of Aquatic Activities		Aquatics Director Name:			
.020 **.103**	Camps that provide activities onsite aquatics (Lifeguard certificate, weeks previous expe supervisory position an aqu 6 21 yrs+,				
.020 .103(A)(B)	Lifeguard (LG) present for swimming/watercraft activities who is 16 yrs+ with a Lifeguard Certificate, CPR and First Aid Certificates				
SWIMMING					
.430	MA *Swimming Pool in compliance with 105 MR 435.000 (Permit Posted) and compliant h VGB Act and pool fence requirements*				

.432	MA Bathing Beach in compliance with 105 we CMR 445.000. Beach signage, ekly clar water sampling, sufficient water ity, and ring buoy				

.204(B)	Camp in compliance with 105 CMR 432.000 (Christian's Law) and M.G.L. c. 111 § 127A ½				
.204(B) **.430(B)**	Swim test to classify swimmers by ability at pools and beaches (Christian's Law)				
.103 **.204(C)**	Proper supervision at swimming venue: • 1 lifeguard per 25 campers • • 1 counselor per 10 campers • Plan to check swimmers - "buddy system" 50+ kids in/near water Aquatics Director present				
.204(A)(D)	Swimming areas clean and safe, no swimming at undesignated sites or at night without lighting				
.204(E)	Piers, floats, and platforms in good repair				
WATERCRAFT ACTIVITIES					
.204(F)(H)	Comply with all Federal and Massachusetts boating laws: M.G.L. c 90B, 323 CMR 2.00: *The Use of Vessels.* 323 CMR 4.00: *The Operation of Personal Watercraft* On-board observer for towing activities				
.204(G)	All participants in watercraft and boating activities shall wear a USCG approved PFD				
.103(B)(1)	Proper supervision of all watercraft activities: • 1 lifeguard per 25 campers • 1 properly trained counselor per 10 campers				
.103(B)(2)	Properly trained counselor supervising paddlesport watercraft activities: • • ; and Paddle Sports course; and • In person training specific to watercraft activities being overseen				
.103(B)(3)	Properly trained counselor supervising sailing or motor-powered watercraft activities:				

		In person training specific to watercraft				

	activities being overseen					
.103(B)(4)(5)	White water activities: previous experience no more difficult than Class imum 2 counselor ercrafts with in s no unclassified water No certified with ARC sailing/motor- Level 4+ Certificate	paddlesport				
.103(B)(6)	Written boating safety plan including procedures for emergencies on the water					
FIREARMS			Instructor(s) Name:			
.103(D)	**Direct Supervisor:** NRA Instructor's certification and maintain compliance with applicable M.G.L.'s **1 counselor per 10 campers**					
.201(A)	Firearms in good condition, stored in locked cabinet. Ammunition locked in separate cabinet					
.201(B)	Shooting range away from other activity areas					
.201(C)	Only non-large capacity, single shot rifles permitted					
.201(D) .201(E)	Firing line in place, no crossing without instructor's permission					
.203	Personal weapons allowed with camp operator's written permission					
ARCHERY						
.103(E)	1 counselor per 10 campers at the range at all times					
.202(A)	Equipment in good condition, stored locked					
.202(B)	Range away from other activity areas, clearly marked danger area with 25 yards clearance behind each target, common firing and ready line in place					
.203	Personal weapons allowed with camp operator's written permission					
HORSEBACK RIDING			Instructor(s) Name:			
.103(F)	Riding instructor(s) licensed in accordance with M.G.L. c. 128, § 2A					
.208(A)	Excursions: 1 Riding Instructor per 10 campers Minimum 2 counselors present during excursions					

.208(A)	Riders must wear hard hat at all times				
.208(B)	Horses boarded in a stable licensed by LBOH in accordance with M.G.L. c. 111, §§ 155 and 158				
CHALLENG	**WE CAOLLU RSE OR CLIMBING**				
.103(G)(1)	Licensed and maintained in accordance with 520 CMR 5.00 Amusement Devices				
.103(G)(2)	Annual inspection with written report				
.103(G)(3)	1 counselor per 10 campers at all times				
	CAMP GROUNDS				
CABINS AN	**D STRUCTURES**				
.457	**Day Camp** provides shelter for ongoing camp activities with certificate of inspection				
.216	**Residential Camp -** Smoke and carbon monoxide detectors provided				
.456	Adequate egresses free from obstruction (780 CMR)				
.453	Lighting provided for stairways				
.454	All structural and interior elements maintained in good repair and in a safe and sanitary condition				

SLEEPING	**AREAS - RESIDENTIAL CAMPS**				
.458	Provide adequate space: **Single bed:** 40ft2/person; • **Bunk bed**: 35ft2/person ; • 50ft2/person requiring special equipment				
.470	Provide separate bed/cot per person with: • 6 ft. between individuals heads • 3 ft. between single beds • 4 ½ ft. between bunks				
.459	Campers/staff with limited mobility housed on ground level; egresses leading to grade/ramp				
.452	Screens and screen doors provided. All doors equipped with self-closing devices				
TENTS					
.217	If less than 400 ft2, clearly labeled as fire resistant. No open flame in or near tent				
	TOILETS/HANDWASH SINKS/SHOWERS				
.360	Approved sanitary drainage system				

.301	Plumbing maintained in good working order				
.370	Adequate # of toilets: **All Camps**: Min. 2 toilets/privy seats for each gender separated by walls/partitions with a door **Day Camp**: 60+ of one gender, provide 1 more toilet for each additional 30 persons of that gender **Residential:** 20+ of one gender, provide 1 more toilet for each additional 10 persons of that gender				
.370(C)(D)	Toilets located less than 200 ft from sleeping rooms, all windows/openings screened, and screen doors equipped with self-closing devices				
.372	Operator shall provide at all toilets/handwash sinks a supply of toilet paper, soap, hand drying method, and covered receptacles				
.373(D)	Hand sanitizer present at additional handwash sinks where standard plumbing is unavailable				
.373	Adequate # of sinks in compliance with 248 CMR: **Day Camp:** 1 sink per every 30 people **Residential Camp**: 1 sink per every 10 people				
.374	Adequate # of showers at **Residential Camps**: 1 shower/tub per 20 people, no duckboards				
.378-.380	Campers with special needs provided sanitary facilities meeting their needs				
.453	Lighting provided				
.375	Adequate ventilation provided for all bathhouses, dressing rooms, shower rooms, and toilets for indoor/outdoor pools				
.376	Hot Water in sufficient quantity and pressure: **Handwash Sink:** 110°F - 130°F **Shower/Bathtub:** 110°F - 120°F				

.374(B) .377	Sanitary facilities in good working order and kept clean, shower room floors washed daily				
LAUNDRY					
.162	**Residential Camp**: Laundry facilities provided				
.472	Bedding and towels laundered, no common towels				
ADDITIONAL CAMP GROUND REQUIREMENTS					
.300	Potable water provided				
.300(B) .304	Adequate and centralized drinking water facilities, no common drinking cups				
.350/.355	Proper storage and disposal of solid waste				
.209	**Residential/Day Camps:** Immediate access to reliable phone with dialing instructions and telephone numbers for HCC, police, emergency medical services, fire department readily accessible				
.213	**Emergency Communication System** to alert campers/staff and elicit a predetermined response				
.450	Site location requirements: Accessible at all times • Surface drainage and traffic conditions do not cause undue hazards • Water supply/sewage disposal facilities are provided •				
.165/.166	Tobacco , alcohol, and marijuana use during camp operating hours prohibited				
.207	Proper storage/operation of power equipment and power tools stored in locked place				
.214	Flammable materials labeled and stored in locked unoccupied building.				

	Hazardous chemicals labeled and stored in				
.400	Rodent and insect control				
.401	Weed and noxious plant control				
	FOOD SERVICE				
.320	Food service in compliance with 105 CMR 590 with food permit prominently displayed. **USDA Summer Food Service** **Program** written				

	documentation of compliance with 105 CMR 590				
.330	Nutritious meals that include a variety of foods served with written menus developed/posted				
.331	**Residential, Travel, Trip Camps** – Provide at least 3 nutritious meals per day which meets recommended dietary guidelines				
.332	**Day Camps** – Provide food which meets recommended dietary guidelines				
.334	Adequately trained staff and equipment to ensure campers with disabilities are eating nutritious meals and meals not denied or forced				
.335	Proper methods for storing meals brought from home and method to provide meals to campers who arrive without a lunch				
.452	Screening provided for food preparation and service areas with self-closing screen doors				
.453	Lighting provided in kitchen and dining area				
.471	Sleeping prohibited in food areas				
MAINTENANCE OF RECORDS					
.145	Operator maintains all records for campers, staff, and volunteers for a minimum of 3 years Records properly destroyed after retention period				
USE THE SPACE BELOW TO DESCRIBE VIOLATIONS MARKED ABOVE					

Field Trip/ Offsite I nerary Form

Camp Site Name and Address:

_____

Name of Program a ending Field Trip/ Offsite Ac vity: _____

Group(s) A ending Field Trip/ Offsite Ac vity:_____

Field Trip Loca on			**Field Trip Date**	
			Field Trip Times	
Address of Trip	# and Street	Neighborhood or City	State	Zip
Telephone of Loca on		**Website of Loca on**		
Departure from Site Time		**Return to Site Time**		
Method of Transporta on				
Special Notes to Parents				

Program/ Staff Informa on

Name of Group a ending Field Trip/ Offsite Ac vity: _____

Contact Informa on for Staff Supervising Trip/Ac vity:

Name:_____ Title:

_____

Cell: _____ Email:_____

Field Trip Loca on:

_____

Field Trip/ Offsite I nerary Form

Sources of Emergency Care:

❑ **Name of Health Care Supervisor on Trip_____**

❑ **Other Sources of Emergency Care:**

MEDICAL/ SAFETY	**Name**	**Telephone**	**Address**	**Email**
Camp HCC				
Hospital				
Police, Fire, EMS	**911**			

SIte Name			Main Telephone	
CAMP Staff Informa on	Name	Office Telephone	Cell Phone	Email
Camp Director 1				
Camp Director 2				
Counselors				
Program Manager				
Other				

Emergency Meet Up Loca on on Trip:_____

Name & Contact Number for Support Staff at trip location:

_____

_____

_____

Field Trip / Offsite Ac vity Check List and Planning Form

Prior to depar ng on any Field Trip or Offsite Ac vity, please ensure the following ac on steps have been completed. These ac on steps are the recommended minimum procedures that must be performed before a group can leave the camp. Addi onal steps may be added.

Administra ve / Planning Steps

Field Trip/ Offsite I nerary Form

❑ Field Trip has been preapproved

❑ I nerary has been provided to parents (minimum of Field Trip Form - Page 1 to accompany weekly schedules)

❑ Field Trip Form (page 2 - completed and provided to Staff Chaperoning Trip)

❑ Review of Trip Procedures before leaving site

Access to Informa on and Supplies by Staff

- Health Care Supervisor for Trip has necessary Medica on for Campers, and shall be responsible for transpor ng to and from Trip according to HCC Recommenda ons

- Each Group traveling offsite must have access to an approved First Aid Kit

- Each Group has updated and complete staff binder that includes:

■ Group(s) Roster and A endance List

○ A Roster that documents the daily a endance of Campers in the Group.

provided to Site Supervisor, Camp Director or designee prior to leaving
site

○ Copies of Camper Registra on Files that include Medical Informa on, Parent/Guardian Emergency Contact Informa on and Consent/ Release Signatures

○ Copies of Accident/ Injury Repor ng Forms

○ Copies of all Camp I neraries and Field Trip/ Offsite Ac vity Forms

○ Lists of all Emergency Telephone Numbers for Emergency Care, as well as all related camp Staff and Administra ve Office Contact Informa on

○ Copies of Staff Medical and Emergency Contact Informa on for that Group.

○ Copies of all Emergency Con ngency Plans for Staff reference

Copies of any Trip Confirma ons/ Reserva ons- with notes about check in, parking, proper, refrigerated storage of bags and lunches at 41F or below.

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
305 South Street, Jamaica Plain, MA 02130

MAURA T. HEALEY
Governor
KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary
ROBERT GOLDSTEIN, MD, PhD
Commissioner
Tel: 617-624-6000
www.mass.gov/dph

To: Camp Directors

From: Pejman Talebian, MA, MPH, Director, Immunization Division

Date: March 26 2025

Subject: Required Immunizations for Children Attending Camp and Camp Staff

According to the U.S. Centers for Disease Control and Prevention, “when more than 95% of people in a community are vaccinated (coverage >95%), most people are protected through community immunity (herd immunity).” There were 285 cases of measles reported in the US during 2024, including one in MA and several in adjacent states. Most of the cases reported in the U.S. were young (73% were under age 20) and unvaccinated or with unknown vaccination history (89%). A single case of measles can expose dozens if not hundreds of people, resulting in risk of illness, medical visits for vaccination and testing, and missed days of work and school due to quarantine of those who lack evidence of immunity to measles. The way to avoid this situation, which can bring a summer camp to a halt, is to ensure that children attending camp and camp staff have evidence of immunity to measles.

Required Vaccines:
Minimum Standards for Recreational Camps for Children, 105 CMR 430.152, has been updated. Immunization requirements for children attending camp follow the Massachusetts school immunization requirements, as outlined in the Massachusetts School Immunization Requirements table, which reflects the newest requirement: meningococcal vaccine (MenACWY) for students entering grades 7 and 11 (on or after the 16th birthday, in the latter case; see the tables that follow for further details). Children should meet the immunization requirements for the grade they will enter in the school year following their camp session. Children attending camp who are not yet school-aged should follow the Childcare/Preschool immunization requirements included in the School Immunization Requirements table.

Campers, staff, and volunteers 18 years of age and older should follow the immunizations outlined in the document Adult Occupational Immunizations.

The following pages include portions of the Massachusetts School Immunization Requirements table and Adult Occupational Immunizations table relevant to camps.

If you have any questions about vaccines, immunization recommendations, or suspect or confirmed disease cases, please contact the MDPH Immunization Division at ImmAssessmentUnit@mass.gov. Address questions about enforcement with your legal counsel.

See the following pages for Grades Kindergarten–6, Grades 7–12 & campers, staff, and volunteers 18 years of age and older

Grades Kindergarten–6¶†

In ungraded classrooms, Kindergarten requirements apply to all students ≥5 years.

DTaP/Tdap	**5 doses;** 4 doses are acceptable if the fourth dose is given on or after the 4th birthday; DT is only acceptable with a letter stating a medical contraindication to DTaP
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose or a fifth dose is required; 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday, and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

§ Address questions about enforcement with your legal counsel.
***** A reliable history of chickenpox includes a diagnosis of chickenpox or interpretation of parent/guardian description of chickenpox by a physician, nurse practitioner, physician assistant, or designee.

See the following pages for Grades 7–12, & campers, staff, and volunteers 18 years of age and older

Grades 7–12†

In ungraded classrooms, Grade 7 requirements apply to all students ≥12 years.

Tdap	**1 dose;** and history of DTaP primary series or age-appropriate catch-up vaccination; Tdap given at ≥7 years may be counted, but a dose at age 11–12 is recommended if Tdap was given earlier as part of a catch-up schedule; Td or Tdap should be given if it has been ≥10 years since last Tdap
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose or a fifth dose is required; 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable; 2 doses of Heplisav-B given on or after 18 years of age are acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday, and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable
Meningococcal **Grade 7–10**	**1 dose**; this dose must be given on or after the 10th birthday. Meningococcal conjugate vaccine, MenACWY (formerly MCV4) and MenABCWY, fulfill this requirement; monovalent meningococcal B (MenB) vaccine is not required and does not meet this requirement **2 doses**; second dose MenACWY (formerly MCV4) must be given on or after the 16th birthday and ≥ 8 weeks after the previous dose; 1 dose is acceptable if it was given on or after the 16th birthday.
Meningococcal **Grade 11–12‡**	Meningococcal conjugate vaccine, MenACWY (MCV4) and MenABCWY, fulfill this requirement; monovalent meningococcal B (MenB) vaccine is not required and does not meet this requirement

§ Address questions about enforcement with your legal counsel.
***** A reliable history of chickenpox includes a diagnosis of chickenpox or interpretation of parent/guardian description of chickenpox by a physician, nurse practitioner, physician assistant, or designee.
‡ Students who are 15 years old in Grade 11 are in compliance until they turn 16 years old.

See the following page for campers, staff, and volunteers 18 years of age and older

Campers, staff, and volunteers 18 years of age and older

MMR	**2 doses;** anyone born in or after 1957; **1 dose;** anyone born before 1957 outside the US; anyone born in the US before 1957 is considered immune; laboratory evidence of immunity to measles, mumps, and rubella is acceptable
Varicella	**2 doses;** anyone born in or after 1980 in the US, and anyone born outside the US; anyone born before 1980 in the US is considered immune; a reliable history of chickenpox* or laboratory evidence of immunity is acceptable
Tdap	**1 dose;** and history of DTaP primary series or age-appropriate catch-up vaccination; Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule; Td or Tdap should be given if it has been ≥ 10 years since Tdap
Hepatitis B	**3 doses;** (or 2 doses of Heplisav-B) for staff whose responsibilities include first aid; laboratory evidence of immunity is acceptable

***** A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Monoclonal antibody		
Respiratory syncytial virus monoclonal antibody (nirsevimab)	[illegible]	[illegible]
COVID-19 vaccine	1vCOV-mRNA	Comirnaty/Pfizer-BioNTech
		Spikevax/Moderna COVID-19 Vaccine
		Novavax COVID-19 Vaccine
	1vCOV-aPS	Dengvaxia
Dengue vaccine	DEN4CYD	Daptacel
Haemophilus influenzae type b vaccine	Hib (PRP-T)	Infanrix ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix
Hepatitis B vaccine	HepB	Vaqta Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated: egg-based)	IIV3	Multiple
Influenza vaccine (inactivated: cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM MenACWY-TT	Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	MenQuadfi Penbraya
Mpox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15 PCV20 PPSV23	Vaxneuvance Prevnar 20 Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo
Rotavirus vaccine	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix Tenivac
Tetanus and diphtheria vaccine	Td	Tdvax
Varicella vaccine	VAR	Varivax
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Quadracel
Measles, mumps, rubella, and varicella vaccine	MMRV	Vaxelis ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

11/21/2024

How to use the child and adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

5 Review contraindications and precautions for vaccine types **(Appendix)**

6 Review new or updated ACIP guidance **(Addendum)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/acip/index.html) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/

Scan QR code for access to online schedule

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

CS310020-E

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

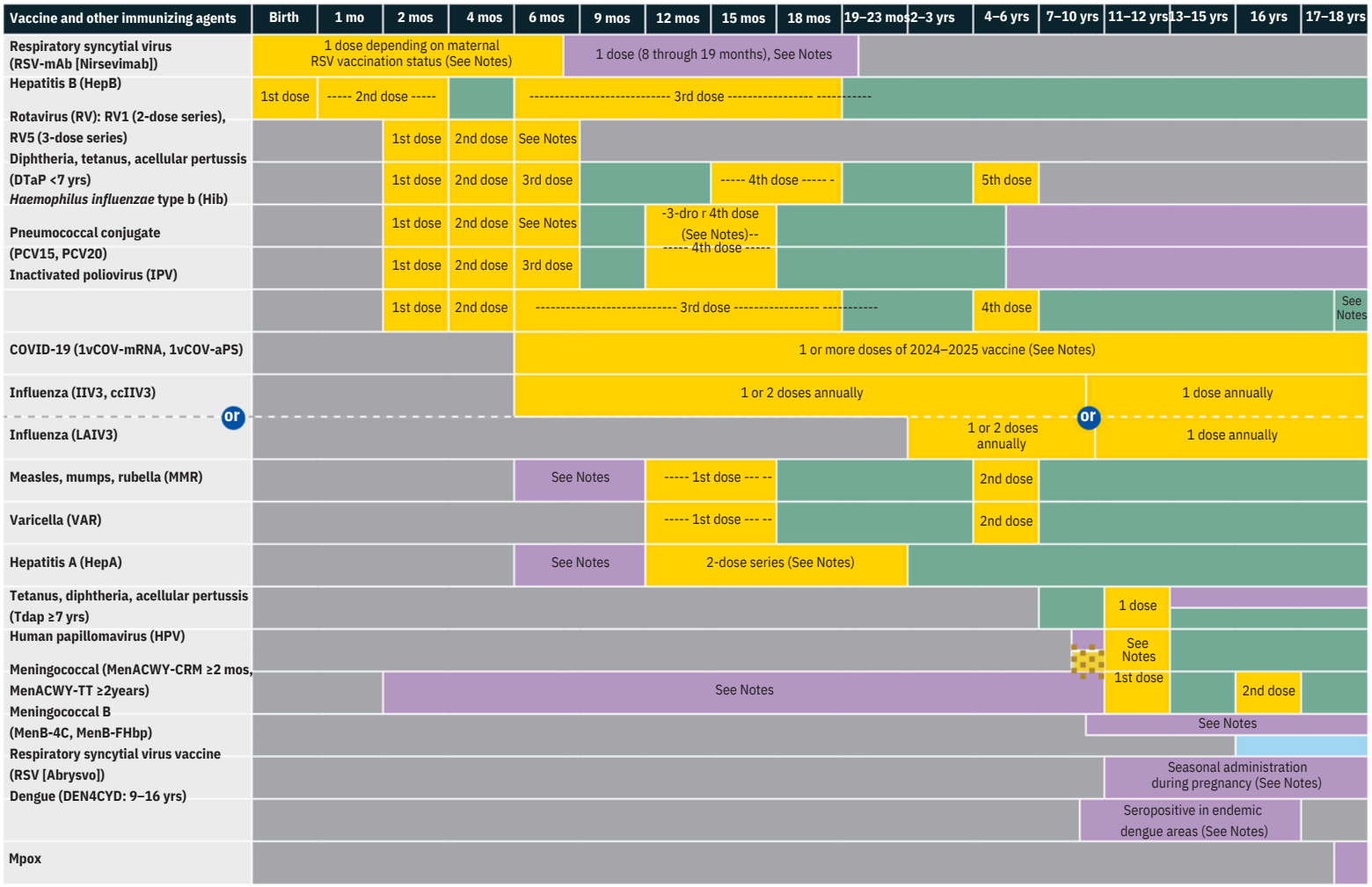

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Children age 4 months through 6 years					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	12 months	**4 weeks**	12	
Varicella	12 months	2 months	**3 months**		
Hepatitis A	MenACWY-CRM		**6 months**		
Meningococcal ACWY	2 years	MenACWY-TT	**8 weeks**	See Notes	See Notes
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks 4 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**Routine dosing intervals are recommended.** **6 months**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**4 weeks** **4 weeks**			
Hepatitis A	N/A				
Hepatitis B	N/A		**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A		**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and counta		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm3	≥15% and ≥200/mm3						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCIDb								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes								
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 yearsc			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at w w w.cdc.gov/vaccines/hcp/acip -recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2025.

Additional information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip -recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination

(minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vacci

Routine vaccination

Age 6 months–4 years

All vaccine doses should be from the same manufacturer.

- **Unvaccinated:**
  - 2 doses 2024–25 Moderna at 0, 4–8 weeks
  - 3 doses 2024–25 Pfizer-BioNTech at 0, 3–8, and at least 8 weeks after dose 2
- **Incomplete initial vaccination series before 2024–25 vaccine with:**
  - **1 dose Moderna:** complete initial series with 1 dose 2024–25 Moderna 4–8 weeks after most recent dose
  - **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech 8 weeks apart (administer dose 1 3–8 weeks after most recent dose).
  - **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.
- **Completed initial vaccination series before 2024–25 vaccine with:**
  - **2 or more doses Moderna:** 1 dose 2024–25 Moderna at least 8 weeks after the most recent dose.
  - **3 or more doses Pfizer-BioNTech:** 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 5–11 years

- **Unvaccinated:** 1 dose 2024–25 Moderna or Pfizer-BioNTech
- **Previously vaccinated before 2024–25 vaccine with 1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 12–18 years

- **Unvaccinated:**
  - 1 dose 2024–25 Moderna or Pfizer-BioNTech
  - 2 doses 2024–25 Novavax at 0, 3–8 weeks
- **Previously vaccinated before 2024–25 vaccine with:**
  - **1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
  - **1 dose Novavax:** 1 dose 2024–25 Novavax 3–8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.
  - **2 or more doses Novavax:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Special situation

Persons who are moderately or severely immunocompromised.

Age 6 months–4 years

Use vaccine from the same manufacturer for all doses ***(initial vaccination series and additional doses*)****.*

- **Unvaccinated:**
  - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna 6 months later [minimum interval 2 months]).May administer additional doses.*
  - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 8 weeks after dose 2, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- **Incomplete initial 3-dose vaccination series before 2024–25 vaccine:**
  - **Previous vaccination with Moderna**

    1 dose Moderna: complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*

    2 doses Moderna: complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*
  - **Previous vaccination with Pfizer-BioNTech**

    1 dose Pfizer-BioNTech: complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 8 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*

    2 doses Pfizer-BioNTech: complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after most recent dose, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*

COVID-19 vaccination - continued

y **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
- **3 or more doses Moderna:** 2 doses 2024–25 Moderna 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna.*
- **3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Pfizer-BioNTech.*

Age 5–11 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

y **Unvaccinated:**
- 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*

y **Incomplete initial 3-dose vaccination series before 2024–25 vaccine:**
- **Previous vaccination with Moderna**

  1 dose Moderna: complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*

  2 doses Moderna: complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
- **Previous vaccination with Pfizer-BioNTech**

  1 dose Pfizer-BioNTech: complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*

  2 doses Pfizer-BioNTech: complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*

y **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Pfizer-BioNTech.*

Age 12–18 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

y **Unvaccinated:**
- 4 doses (**3-dose initial series Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- 4 doses (**3-dose initial series Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- 3 doses (**2-dose initial series Novavax** at 0, 3 weeks, followed by 1 dose Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

y **Incomplete initial vaccination series before 2024–25 vaccine:**
- **Previous vaccination with Moderna**

  1 dose Moderna: complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

  2 doses Moderna: complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **Previous vaccination with Pfizer-BioNTech**

  1 dose Pfizer-BioNTech: complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

  2 doses Pfizer-BioNTech: complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **Previous vaccination with Novavax**

  1 dose Novavax: complete initial series with 1 dose 2024–25 Novavax at least 3 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

COVID-19 vaccination - continued

y **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**
- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **2 or more doses Novavax:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

***Additional doses of 2024–25 COVID-19 vaccine for moderately or severely immunocompromised:** based on shared clinical decision-making and administered at least 2 months after the most recent dose (see Table 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#table-02.). For description of moderate and severe immunocompromising conditions and treatment, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim- considerations-us.html#immunocompromising-conditions-treatment.

Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose.

For information about transition from age 4 years to age 5 years or age 11 years to age 12 years during COVID-19 vaccination series, see Tables 1 and 2 at www.cdc.gov/vaccines/covid-19/clinical- considerations/interim- considerations-us.html.

For information about interchangeability of COVID-19 vaccines, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim- considerations-us.html#I nterchangeabilit y.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

y Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection - 3-dose series administered at 0, 6, and 12 months

y Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/index.html

y Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

y 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by booster doses at ages 15–18 months and 4–6 years)
- **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
- **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

y Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.

y For other catch-up guidance, see Table 2.

Special situations

y **Children younger than age 7 years with a contraindication specific to the pertussis component of DTaP:** May administer Td for all recommended remaining doses in place of DTaP. Encephalopathy within 7 days of vaccination when not attributable to another identifiable cause is the only contraindication specific to the pertussis component of DTaP. For additional information, see www.cdc.gov/pertussis/hcp/vaccine -recommendations/td- offlabel.html.

y **Wound management in children younger than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine:** For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

y **ActHIB, Hiberix, Pentacel, or Vaxelis:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
- *Vaxelis is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.

y **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

y **American Indian and Alaska Native infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

y **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age12–15 months or 8 weeks after dose 2 (whichever is later).

y **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.

y **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.

y **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age12–59 months and at least 8 weeks after dose 2.

y **1 dose administered at age 15 months or older:** No further doses needed

y **Unvaccinated at age 15–59 months:** Administer 1 dose.

y **Previously unvaccinated children age 60 months or older who are not considered high risk:** Catch-up vaccination not required.

For other catch-up guidance, see Table 2. Vaxelis can be used for catch-up vaccination in children younger than age 5 years. Follow the catch-up schedule even if Vaxelis is used for one or more doses. For detailed information on use of Vaxelis see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Notes

Haemophilus influenzae type b vaccination - continued

Special situations

y **Chemotherapy or radiation treatment:**
Age 12–59 months
- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.

y **Hematopoietic stem cell transplant (HSCT):**
- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

y **Anatomic or functional asplenia (including sickle cell disease):**
Age 12–59 months
- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5 years or older
- 1 dose

y **Elective splenectomy:**
Unvaccinated* persons age 15 months or older
- 1 dose (preferably at least 14 days before procedure)

y **HIV infection:**
Age 12–59 months
- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5–18 years
- 1 dose

y **Immunoglobulin deficiency, early component complement deficiency, or early component complement inhibitor use:**
Age 12–59 months
- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* = Less than routine series (through age 14 months) **or no doses (age 15 months or older)

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

y **2-dose series** (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

y **Unvaccinated persons through age 18 years should complete a 2-dose series** (minimum interval: 6 months).

y Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.

y Adolescents age 18 years or older may receive HepA-HepB (Twinrix) as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

y Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
- **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses (separated by at least 6 months) between age 12–23 months.
- **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

th)

Routine vaccination

y **Mother is HBsAg-negative**
- 3-dose series at age 0, 1–2, 6–18 months **(use monovalent HepB vaccine for doses administered before age 6 weeks)**
  Birth weight ≥2,000 grams: 1 dose within 24 hours of birth if medically stable
  Birth weight <2,000 grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams)
- Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum inter vals).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations.
- **Final (3rd or 4th) dose:** age 6–18 months **(minimum age 24 weeks)**

y **Mother is HBsAg-positive**
- **Birth dose (monovalent HepB vaccine only):** administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** in separate limbs within 12 hours of birth, regardless of birth weight.
- **Birth weight <2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
- **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**.
- Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Hepatitis B vaccination - continued

y **Mother is HBsAg-unknown**

If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive.

- **Birth dose (monovalent HepB vaccine only):**

  Birth weight ≥2,000 grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.

  Birth weight <2,000 grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses).

- **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**.
- If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

y Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals.

y Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).

y Adolescents age 18 years may receive:

- **Heplisav-B:** 2-dose series at least 4 weeks apart
- **PreHevbrio*:** 3-dose series at 0, 1, and 6 months
- **HepA-HepB (Twinrix):** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

y Revaccination is generally not recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.

y **Post-vaccination serology testing and revaccination** (if anti-HBs <10mIU/mL) is recommended for certain populations, including:

- Infants born to HBsAg-positive mothers
- Persons who are predialysis or on maintenance dialysis
- Other immunocompromised persons
- For detailed revaccination recommendations, see www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant women.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

y HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated.

y 2- or 3-dose series depending on age at initial vaccination:

- **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
- **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)

y No additional dose recommended when any HPV vaccine series **of any valency** has been completed using recommended dosing intervals.

Special situations

y **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.

y **History of sexual abuse or assault:** Start at age 9 years

y **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination (minimum age: 6 months [IIV3], 2 years [LAIV3],18 years [recombinant influenza vaccine, RIV3])

Routine vaccination

y Use any influenza vaccine appropriate for age and health status annually:

- **Age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2024, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
- **Age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2024: 1 dose.
- **Age 9 years or older:** 1 dose
- **Age 18 years solid organ transplant recipients receiving immunosuppressive medications:** high-dose inactivated (HD-IIV3) and adjuvanted inactivated (aIIV3) influenza vaccines are acceptable options. No preference over other age-appropriate IIV3 or RIV3.

y For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

y For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

y **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protective environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

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Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Measles, mumps, and rubella vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

y 2-dose series at age 12–15 months, age 4–6 years

y MMR or MMRV* may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV* may be used if parents or caregivers express a preference.

Catch-up vaccination

y **Unvaccinated children and adolescents:** 2-dose series at least 4 weeks apart*

y The maximum age for use of MMRV* is 12 years.

Special situations

y **International travel**

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.*
- **Children age 12 months or older:**

  Unvaccinated: 2-dose series (separated by at least 4 weeks*) before departure

  Previously received 1 dose: administer dose 2 at least 4 weeks after dose 1*

y In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** If MMRV is used, the minimum interval between MMRV doses is 3 months.

Meningococcal serogroup A,C,W,Y vaccination
(minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi]), 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination

y 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

y **Age 13–15 years:** 1 dose now and booster at age 16–18 years

y **Age 16–18 years:** 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

y **Menveo***

- Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
- Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
- Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

y **MenQuadfi**

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel to countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**

y **Children younger than age 24 months:**

- **Menveo* (age 2–23 months)**

  Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)

  Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)

  Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)

y **Children age 2 years or older:** 1 dose Menveo* or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits: 1 dose Menveo* or MenQuadfi

Adolescent vaccination of children who received MenACWY prior to age 10 years:

y **Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease** (e.g., those with complement component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.

y **Children for whom boosters are not recommended**

(e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

* *Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.*

Note: For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see "Meningococcal serogroup B vaccination" section below for more information).

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Meningococcal serogroup B vaccination
(minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba; MenACWY-TT/MenB-FHbp, Penbraya])

Shared clinical decision-making

y **Adolescents not at increased risk age 16–23 years (preferred age 16–18 years)* based on shared clinical decision-mak ing.**
- **Bexsero or Trumenba (use same brand for all doses):**

2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job -aid-scdm-mening-b -shared- clinical- decision-mak ing.pdf

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use.
- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see w w w.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Children age 10 years or older may receive a dose of Penbraya (MenACWY–TT/MenB–FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Mpox vaccination
(minimum age: 18 years [Jynneos])

Special situations

y **Age 18 years and at risk for mpox infection:** complete 2-dose series, 28 days apart.

Risk factors for mpox infection include:
- Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
  - A new diagnosis of at least 1 sexually transmitted disease
  - More than 1 sex partner
  - Sex at a commercial sex venue
  - Sex in association with a large public event in a geographic area where mpox transmission is occurring
- Persons who are sexual partners of the persons described above
- Persons who anticipate experiencing any of the situations described above

y **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.

For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination- over view.html

Pneumococcal vaccination
(minimum age: 6 weeks [PCV15], [PCV 20]; 2 years [PPSV23])

Routine vaccination with PCV

y 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

y Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose

y For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Special situations

Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years

y Any incomplete* PCV series with:
- 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
- Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)

y Completed recommended PCV series but have not received PPSV23.
- Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
- Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

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Pneumococcal vaccination - continued

Age 6–18 years

y Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**

y Received PCV before age 6 years but have not received PPSV23
- Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
- Not previously received PCV20: 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

y Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.

y Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

y Any incomplete* PCV series:
- 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
- Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)

y Completed recommended PCV series but have not received PPSV23
- Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
- Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

y Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**

y Received PCV before age 6 years but have not received PPSV23
- Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
- Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

y Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

y Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: wcms-wp.cdc.gov/pneumococcal/hcp/vaccine -recommendations/app.html

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

y 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.

y 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

y In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.

y **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus vaccine (OPV), either mixed OPV-IPV or OPV-only series:

y Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See w w w.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.

y Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
- Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
- Doses of OPV administered on or after April 1, 2016, should not be counted.
- For guidance to assess doses documented as "OPV," see w w w.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.

y For other catch-up guidance, see Table 2.

Special situations

y **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Respiratory syncytial virus immunization
(minimum age: birth [Nirsevimab, RSV-mAb, Beyfortus])

Routine immunization

y **Infants born October – March in most of the continental United States***
- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

y **Infants born April–September in most of the continental United States***
- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

y **Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:**
- 1 dose nirsevimab shortly before start of second RSV season*

y **Ages 8–19 months who are American Indian or Alaska Native:** 1 dose nirsevimab shortly before start of second RSV season*

y **Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:** 1 additional dose of nirsevimab after surgery. See www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf

***Note:** While the timing of the onset and duration of RSV season may vary, administration of nirsevimab is recommended October through March in most of the continental United States (optimally October through November or within 1 week of birth). Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

Respiratory syncytial virus vaccination
(RSV [Abrysvo])

Routine vaccination

y **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose Abrysvo. Administer RSV vaccine regardless of previous RSV infection.
- Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.

y **All other pregnant women:** RSV vaccine not recommended

y **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

Rotavirus vaccination
(minimum age: 6 weeks)

Routine vaccination

y **Rotarix:** 2-dose series at age 2 and 4 months

y **RotaTeq:** 3-dose series at age 2, 4, and 6 months

y If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

y Do not start the series on or after age 15 weeks, 0 days.

y The maximum age for the final dose is 8 months, 0 days.

y For other catch-up guidance, see Table 2.

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Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Age 11–12 years:** 1 dose Tdap (adolescent booster)
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in gestational weeks 27 through 36, even if the person has received Tdap previously.

Note: Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)
- **Age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years
  - **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years
- **DTaP inadvertently administered on or after age 7 years**:
  - **Age 7–9 years**: DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.
  - **Age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster dose.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.

- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP or 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered before age 4–6 years if at least 3 months have elapsed since dose 1 (if dose 2 is inadvertently administered at least 4 weeks after dose 1, it can be counted as valid).

***Note:** For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years**: Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
  - **Age 13 years and older**: Routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of *MMRV* is 12 years.

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Appendix Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions, Prevention and Control of Seasonal Influenza with Vaccine Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season | MMWR (cdc.gov), *and* Contraindications and Precautions for COVID-19 Vaccination

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended1	Precautions2
COVID-19 mRNA vaccines [Pfizer-BioNTech, Moderna]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine3	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID-19 vaccine3; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
COVID-19 protein subunit vaccine [Novavax]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Novavax COVID-19 vaccine3	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Novavax COVID-19 vaccine3; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Novavax COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component4 (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable (ccIIV3) [Flucelvax]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component4 of ccIIV3	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable (RIV3) [Flublok]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component4 of RIV3	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated (LAIV3) [Flumist]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component4 (excluding egg) • Children age 2–4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons age 5 years old or older • Persons with underlying medical conditions other than those listed under contraindications that might predispose to complications after wild-type influenza virus infection, e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus) • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should **NOT** be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
3. See package inserts and FDA EUA fact sheets for a full list of vaccine ingredients. mRNA COVID-19 vaccines contain polyethylene glycol (PEG).
4. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See Package inserts for U.S.-licensed vaccines.

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended1	Precautions2
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Lack of laboratory confirmation of a previous dengue infection	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • Horis tteotrayn oufs A-trothxouisd-–tycpoen thayinpienrgs evnascictiinviet;y d reefaecrt ivoancsc ianfatetiro an purn tetanus-toxoid-containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Younger than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 including yeast • Pregnancy: PreHevbrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated4	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB) [Twinrix]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • *Pregnancy: HPV vaccination not recommended*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Stoenrge-free rimm inumnoudneoficdiepnpcreys (sei.ge., tnneenraaptyo toorg pica tamedn tsso wlidit htu HmIVor isn,f reeccteioipnt w ohf oc haerem soetvheerrealpyy i,m cmonugneoncitoaml ipmrommuinsoedde)ficiency	• Moderate or severe acute illness with or without fever • Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)
Measles, mumps, rubella, and varicella (MMRV)	• Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent • For MMRV only: HIV infection of any severity	Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever • For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology • For MenACWY-CRM only: Preterm birth if younger than age 9 months
Meningococcal ACWY (MenACWY) MenACWY-CRM [Menveo] MenACWY-TT [MenQuadfi]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • For Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid— or CRM197—containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever • Pregnancy
Meningococcal B (MenB) MenB-4C [Bexsero] MenB-FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever • Moderate or severe acute illness, with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Severe allergic reaction to a tetanus toxoid-containing vaccine	
Mpox [Jynneos]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV) Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid-containing vaccine or its component3 • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Moderate or severe acute illness with or without fever • Moderate or severe acute illness with or without fever • Pregnancy
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component5	• Moderate or severe acute illness with or without fever
RSV monoclonal antibody (RSV-mAb)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Moderate or severe acute illness with or without fever • Altered immunocompetence other than SCID
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Moderate or severe acute illness with or without fever • Chronic gastrointestinal disease
Rotavirus (RV) RV1 [Rotarix] RV5 [RotaTeq]	• Severe combined immunodeficiency (SCID) • History of intussusception • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever • Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Eanro Tthdearp1 doennhyti.FE ianbcleep chaaulsoep awtihthy i(ne 7.g .d, acyosm oaf ,a ddemcrineiassteradt iloenv eolf o pfr ceovniosucsio duossnee sosf ,D pTrPol,o DnTgaePd, soeri zTudraeps) not attributable to vaccine	• Moderate or severe acute illness with or without fever • Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR) Measles, mumps, rubella, and varicella (MMRV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent • For MMRV only: HIV infection of any severity	• Moderate or severe acute illness with or without fever • If using MMRV, see MMR/MMRV for additional precautions

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2. Whmhemnu an ipzraetcioanu.t iwown wis. pcdrecs.geonvt,/ vvaaccccinneasti/ohnc ps/haocuipld- rgeecnse/graelnlye rbael-dreecfesr/rceodn tbruatin mdiigchatti obnes i.nhdtimcal.ted if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kro
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevbrio while pregnant, please visit www.prehevbrio.com/#safety.
5. Full prescribing information for BEYFORTUS (nirsevimab-alip) www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf.

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

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Advisory regarding the Parent/Guardian Authorization Administer Medication to a Camper

CONTACTS: Steven F. Hughes, Director (617) 624-5757, or

David T. Williams, Senior Analyst (781) 774-6612

RE: Clarification of Recreational Camp document titled: Authorization to Administer Medication to a Camper (completed by parent/guardian)

DATE: March 29, 2018

Dear Parent/Guardian,

If your child may need medication during camp, the camp is required by 105 CMR 430.000: *Minimum Standards for Recreational Camps for Children* (State Sanitary Code, Chapter 19) to have the camp to follow certain procedures to ensure minimum safety requirements are met (105 CMR attached consent form gives the camp permission to store and administer medication to the camper by certain trained
camp staff. The criteria below explain the requirements for those medications and the procedures the camp must follow. It is important for you to carefully review these criteria and discuss any speci ic questions with camp staff.

- **If providing prescription medications for the camp to administer to your child, please complete the attached form "Authorization to Administer Medication to a Camper" completely.**
  -
  -

    Specify "NA" – Not Applicable, where appropriate.
    Be sure to sign the form.
- **Medication that will be administered at camp must be provided by the parent/guardian to the camp in the original container(s) bearing the pharmacy label with the following information:**

-
- the date of filling
- the pharmacy name and address o the illing pharmacist's initials o the serial number of the prescription o the name of the patient
- the name of the prescribing practitioner o the name of the prescribed medication directions for use and cautionary statements contained in such prescription or required by law o if tablets or capsules, the number in the container
- All over-the-counter medications must be kept in the original containers containing the original label, which shall include the directions for use

_____

1 There is an exception for epinephrine auto injectors, where other trained employees may administer with parent/guardian consent.

- **Medications must be stored at camp in a secure location.**
- **When camp session ends, all remaining medications must be returned to the parent or guardian whenever possible or destroyed.**
- **Prescription medication may only be administered by the camp's Health Care Consultant (HCC) or designated Health Care Supervisor (HCS)1**

  o The Health Care Consultant is a licensed health care professional authorized to administer prescription medications, but may not be required to be on-site at all times

  o The Health Care Supervisor may or may not be a licensed health care professional authorized to administer prescription medications. If they are not a licensed health care professional, they must be trained by the Health Care Consultant and the administration of medications must be under the professional oversight of the Health Care Consultant. A Health Care Supervisor must be on-site at all times the camp is operating.

- **If your child is insulin dependent,**

  you may grant them permission to self-administer if you deem appropriate. The camp's Health Care Consultant will also need to approve self-administration, and a Health Care Supervisor will need to be present to oversee self-administration. There are boxes in the attached forms where you can confirm or deny this permission.

- **If your child has an allergy requiring an epinephrine**

  prescription (epinephrine auto injector): o
  You may grant them permission to self-administer if you deem appropriate. The camp's Health Care Consultant will also need to approve self-administration.

  o You may consent to trained employees, other than the HCC or HCS, administering the epinephrine auto injector during an emergency

- **Every camp must have a written policy for the administration of medications**

  that identifies the
  individuals who will administer medications, as well as storage and record keeping procedures. You may ask the camp for a copy of their policy

,

Massachusetts Department of Public Health

Administration of Epinephrine Auto-Injectors Test of Competency Checklist

To be completed at the time an individual authorized to administer an epinephrine auto-injector at a recreational camp is assessed for compliance with 105 CMR 430.160(I)(2).

Name: _

Date of Assessment:

Epinephrine Auto-Injector Brand: _____

Checklist	
Steps to Follow:	**Check (√)**
Demonstrate safe handling, proper storage, and proper disposal of epinephrine auto-injectors.	
Demonstrate the ability to administer an epinephrine auto-injector properly.	
Demonstrate an understanding of signs and symptoms of an allergic reac on.	
Describe allergy management and exposure preven on for campers with a known allergy.	
Describe the proper emergency ac on to be taken in response to cases of severe allergic reac on: • steps to follow; • when to call 911; and • no fica on of parent/guardian and health care consultant.	
Demonstrate the appropriate and correct record keeping regarding use of an epinephrine auto-injector.	
Use resources appropriately, including the health care consultant, parent/guardian or emergency services.	
~~Comments:~~	
Signatures:	

Health Care Consultant

Name and Title: _____

Signature: _____

Date

Staff

Signature: _____

Date

DPH Standards for Training Health Care Supervisor and Other Staff on Use of Epinephrine AutoInjectors

Every health care supervisor (HCS) shall complete a training and a test of competency on administra on of epinephrine auto-injectors under the direc on of the health care consultant. However, due to the emergent nature of anaphylac c reac ons, other staff may also be trained in the administra on of an epinephrine autoinjector under the direc on of the health care consultant. The parent/guardian and the health care consultant must have given wri en informed consent for unlicensed staff to administer an epinephrine auto-injector. The parent/guardian authoriza on should also contain a separate approval for self-administra on by the camper, if applicable.

Training Topics: An approved training will address, at a minimum, the following issues:

1. Confiden ality
2. Understanding Allergic Reac ons and the Signs of Anaphylaxis

- Mild versus Severe Allergic Reac on Symptoms

1. Allergy Management and Exposure Preven on for Campers with a Diagnosed Allergy
2. Emergency Ac on Plan for Anaphylaxis
3. Proper Use of an Epinephrine Auto-Injector
4. Documenta on and Record-keeping

Test of Competency: Each health care supervisor, and other staff, who are trained in the administra on of epinephrine auto-injectors under the direc on of the health care consultant must have a documented test of competency to administer epinephrine auto-injectors. At a minimum, they must:

1. Demonstrate safe handling, proper storage, and proper disposal of epinephrine auto-injectors.
2. Demonstrate the ability to administer an epinephrine auto-injector properly.
3. Demonstrate an understanding of signs and symptoms of an allergic reac on.
4. Describe allergy management and exposure preven on for campers with a known allergy.
5. Describe the proper emergency ac on to be taken in response to cases of severe allergic reac on:
   - steps to follow;
   - when to call 911; and
   - no fica on of parent/guardian.
6. Demonstrate the appropriate and correct record keeping regarding use of an epinephrine auto-injector.
7. Use resources appropriately, including the health care consultant, parent/guardian or emergency services.

Massachusetts Department of Public Health

Administration of Prescription Medication Test of Competency Checklist

To be completed at the time the Health Care Supervisor (other than a licensed medical professional) is assessed by the camp's Health Care Consultant for compliance with 105 CMR 430.160(I)(1).

Health Care Supervisor's Name:

Date of Assessment: Medica on Name(s):

❑ See a ached list

Route: Oral

Tablet

Checklist	
Steps to Follow:	**Check (√)**
Demonstrate safe handling and proper storage of medica on.	
Demonstrate the ability to administer medica on properly: • accurately read and interpret the medica on label; • follow the direc ons on the medica on label correctly; and • accurately iden fy the camper for whom the medica on is ordered.	
Demonstrate the appropriate and correct record keeping regarding medica ons given and/or self-administered.	
Demonstrate correct and accurate nota ons on the record if medica ons are not taken/given either by refusal or omission and when adverse reac ons occur.	
Describe the proper ac on to be taken if any error is made in medica on administra on or if there is an adverse reac on possibly related to medica on.	
Use resources appropriately, including the consultant, parent/guardian or emergency services when problems arise including: • steps to follow; • when to call 911; • no fica on of parent/guardian and health care consultant; and • appropriate procedures that assure confiden ality.	
Comments:	
Signatures:	

Health Care Consultant

Name and Title: _____

Signature: _____

Date

Health Care Supervisor

Signature: _____

Date

DPH Standards for Training Health Care Supervisor in Medica on Administra on

Each recrea onal camp must ensure that the health care supervisor(s) (HCS) can meet the health and medical needs of each individual camper. The camp's health care consultant (HCC) must provide training and document the test of competency of every health care supervisor.3 This training does not need to be submi ed for prior approval but must be made available by request or during an inspec on.

Training Topics: An approved training will address, at a minimum, the following issues:

1. Confiden ality
2. The Role of the Health Care Supervisor
3. Limits of the Health Care Supervisor
4. Effects and Possible Side Effects of all Medica on Administered
5. Steps in Medica on Administra on 6. Camp Safeguards and Policies

Test of Competency: Each health care supervisor must have a documented test of competency to administer medica ons. At a minimum, the health care supervisor must:

1. Demonstrate safe handling and proper storage of medica on.
2. Demonstrate the ability to administer medica on properly:
    - accurately read and interpret the medica on label;
    - follow the direc ons on the medica on label correctly; and
    - accurately iden fy the camper for whom the medica on is ordered.
3. Demonstrate the appropriate and correct record keeping regarding medica ons given and/or selfadministered.
4. Demonstrate correct and accurate nota ons on the record if medica ons are not taken/given either by refusal or omission and when adverse reac ons occur.
5. Describe the proper ac on to be taken if any error is made in medica on administra on or if there is an adverse reac on possibly related to medica on.
6. Use resources appropriately, including the health care consultant, parent/guardian or emergency services when problems arise.
7. Understand and be able to implement:
    - emergency plans including when to call 911
    - appropriate procedures that assure confiden ality.

3 If HCS is a Massachuse s licensed physician, nurse, or physician's assistant, that cer fica on is evidence of proper training and competency.

Camp Medica on Administra on Training Checklist:

1. Confiden ality:		
	Importance of not sharing informa on about campers or medica ons with anyone unless directed to do so by the HCC	
2. Role of Health Care Supervisor:		
	Administer Medica on only by Specific HCC Order to Specific Child	
	Follow Instruc ons on Medica on Sheet	
	Record Time and Effects Observed	
	Reports Any Problem or Uncertainty	
3. Limits of the Health Care Supervisor:		
	HCS may not administer ANY medica on without HCC approval	
	HCS may not administer ANY medica on without parent/guardian permission	
	HCS may not administer insulin (unless within scope of prac ce or in accordance with 105 CMR 430.160(G))	
4. Effects and Possible Side Effects of all Medica on Administered:		
	Describe Effects of Medica ons	
	Discuss Common Side-Effects of Medica ons (drowsiness, vomi ng, allergic reac on)	
	Report All Changes that may be side-effects to HCC and Parent/Guardian	
	Record All Changes that may be side-effects in log	
5. Steps in Medica on Administra on:		

5 Rights of Medica on Administra on	1. Right Camper 2. Right Medica on 3. Right Dosage 4. Right Time 5. Right Route	
Steps in Medica on Administra on	1. Iden fy Camper 2. Read Medica on Administra on Sheet 3. Wash Hands 4. Select and Read Label of Medica on 5. Prepare Medica on and Read Label Again 6. Administer Medica on and Make Sure Medica on is Taken. 7. Replace Medica on in Secure Loca on 8. Lock or Secure Loca on 9. Document in Medica on Log	
Steps in Supervising Self-Administra on	1. Iden fy Camper 2. Read Medica on Administra on Sheet 3. Select and Read Label of Medica on 4. Observe Student Prepare and Take Medica on 5. Replace Medica on in Secure Loca on 6. Lock or Secure Loca on 7. Document in Medica on Log	
6. Camp Safeguards and Policies		
	Report Any Error to HCC and Parent/Guardian including: 1. Camper Given Wrong/Unapproved Medica on 2. Camper Refuses Medica on 3. Camper Has Unusual or Adverse Reac on Possibly Related to Medica on	
	Review Camp's Emergency Plan and when to call Emergency Services	

June 2024

Sample Health Care Consultant Acknowledgement of On-Site Medications

Health Care Consultant Information		
Name:		
MA License Number:		
Type of Medical License: Physician Physician Assistant Nurse Prac oner		
Address		
City:	State:	Zip Code:
Additional Contact Information		
Phone: Fax:		
Email:		

I, _____, acknowledge that I serve as the Health
(Print Name)

Care Consultant for _____.

(Camp Name)

As such, I hereby authorize the ~~list of a ached~~ medica ons to be administered to campers as prescribed, provided that, the medica ons are delivered to the camp, maintained by the camp, and administered in accordance with Commonwealth of Massachuse s Regula ons 105 CMR 430.160 and that the parent/guardian of the camper has provided wri en permission for the administra on of the medica on.

I am not the prescribing physician for these medica ons. My signature indicates only that I have reviewed the a ached list of medica ons and associated poten al side effects, adverse reac ons and other per nent informa on with all personnel listed below, who administer medica ons or designated health care supervisors who are appropriately trained to and are doing so under my professional oversight.

Name(s) of individual authorized to administer medica ons at camp:

_____

_____

_____

_____

_____

Signature: _____

Date: _____

Below are the prescrip on medica ons reviewed by the Health Care Consultant to be administered at

_____ by individuals authorized to administer medica ons at camp.

(Camp Name)

Name of Medication(s)	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	

17.	
18.	
19.	
20.	

***Please use mul ple copies of this page if addi onal medica ons are administered at camp.**

Sample Daily Log for Medication Administration (complete for EACH medication)

Camper's Name, Gender and Age:

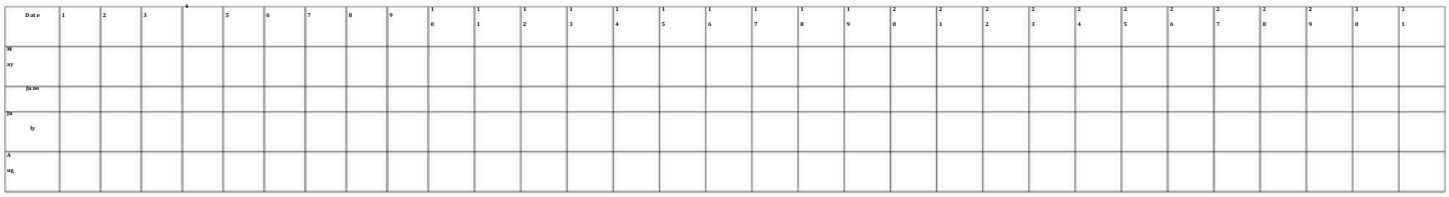
Name and Dosage of

Medica on:

Route: Frequency:

Year:

Direc ons: Ini al with me of medica on administra on. Include a complete printed name, signature and ini als of person administering medica on below.



Ini als of individual administering medica on Printed Name and Signature of individual administering medica on

1.	
2.	
3.	
4.	
5.	

Codes for administra on: (A) Absent (E) Early Dismissal (F) Field Trip (N) No Medica on available

(O) No Show (X

WHAT IS A LICENSED RECREATIONAL CAMP FOR CHILDREN?

A licensed recrea onal camp for children may be a day or residen al (overnight) program that offers recrea onal ac vi es and instruc on to campers. There are certain factors, such as the number of children the camp serves, the length of me the camp is in session, and the type of en ty opera ng a program, that determine whether a program is considered a recrea onal camp under Massachuse s law and regula ons and therefore must be licensed (see M.G.L. c. 111, §127A and 105 CMR 430.000: Minimum

Standards for Recrea onal Camps for Children).

WHAT DOES IT MEAN FOR A

RECREATIONAL CAMP TO BE LICENSED?

If a camp meets the defini on of a recrea onal camp it must be inspected and licensed by the local board of health in the city or town where the camp is located. It must also meet all regulatory standards established by the Massachuse s Department of Public Health (MDPH) and any addi onal local requirements.

ARE ALL SUMMER PROGRAMS REQUIRED TO BE LICENSED AS RECREATIONAL CAMPS FOR CHILDREN?

No. Programs that do not meet the legal defini on of a recrea onal camp for children are not subject to MDPH's regulatory provisions and therefore do not have to follow the requirements that apply to licensed recrea onal camps and are not subject to inspec ons by either MDPH or a local board of health.

WHAT IS THE PURPOSE OF THE REGULATIONS?

The regula ons establish minimum health, safety, sanitary, and housing standards to protect the wellbeing of children who are in the care of recrea onal camps for children in Massachuse s. These regula ons include:

- requiring camps to perform criminal record background checks on each staff person and volunteer prior to employment and every 3 years for permanent employees;
- requiring proof of camper and staff immunizations;
- requiring proof of appropriate training, certification, or experience for staff conducting or supervising specialized or high risk activities (including swimming and watercraft activities).

WHAT DOES THE LOCAL HEALTH DEPARTMENT EVALUATE AS PART OF A CAMP INSPECTION?

The primary purpose of the inspec on is to ensure that the camp provides an appropriate environment to protect the health, safety, and well-being of the campers. Examples of things inspectors look for include: safe structures and equipment; adequate sanitary facili es; sufficient supervision of the campers; appropriate plans in case of medical emergencies, natural, and other physical disasters; sufficient health care coverage; and injury and fire preven on plans. Contact the local health department or local board of health in the community in which the camp is located to find out mandatory requirements, policies, and standards.

WHERE CAN I GET INFORMATION ON THE STATUS OF A RECREATIONAL CAMP'S LICENSE?

Contact the local health department or board of health in the community where the camp is located to determine if the camp is a licensed recrea onal camp for children, confirm the status of the camp's license, and obtain a copy of the camp's most recent inspec on report.

ARE RECREATIONAL CAMPS REQUIRED TO PROVIDE COPIES OF OPERATING PLANS AND PROCEDURES?

Yes. The camp must provide copies of any of the required plans and procedures on request.

ARE THERE MINIMUM QUALIFICATIONS FOR CAMP COUNSELORS IN MASSACHUSETTS?

Yes. All counselors in licensed recrea onal camps are required to have at least four weeks experience in a supervisory role with children or four weeks experience with structured group camping. Counselors must also complete an orienta on program before campers arrive at camp. Any counselor who supervises children in ac vi es such as horseback riding, hiking, swimming, and other events must also have appropriate specialized training, cer fica on, and experience in the ac vity. You may ask to see proof that a counselor is cer fied in a par cular ac vity.

HOW OLD DO CAMP COUNSELORS HAVE TO BE?

There are different age requirements depending on the type of camp. A counselor working at a licensed residen al (overnight), sports, travel, trip, or medical specialty camp must be 18 years of age or have graduated from high school. Counselors working at a day camp must be at least 16 years of age. All counselors at licensed camps in Massachuse s are required to be at least three years older than the campers they supervise.

IS THE CAMP REQUIRED TO CONDUCT BACKGROUND CHECKS ON CAMP STAFF?

Yes. For all camp staff and volunteers, the licensed recrea onal camp for children must conduct a background check that includes obtaining and reviewing the applicant's previous work history and confirming three posi ve references. The camp must also obtain a Criminal Offender Record Informa on (CORI) history/juvenile report history from the Massachuse s Department of Criminal Jus ce Informa on Services to determine whether the applicant has a juvenile record or has commi ed a crime that would indicate the applicant is not suitable for a posi on with campers. The camp must conduct CORI re-checks every three years for permanent employees with no break in service.

The local health department will verify that CORI checks have been conducted during their annual licensing inspec on. If an applicant resides in another state or in a foreign jurisdic on, where prac cable, the camp must also obtain from the applicant's criminal informa on system board, the chief of police, or other relevant authority a criminal record check or its recognized equivalent. The camp is required to hire staff and volunteers whose backgrounds are free of conduct that bears adversely upon his or her ability to provide for the safety and well-being of the campers.

IS THE CAMP REQUIRED TO CHECK STAFF AND VOLUNTEER BACKGROUNDS FOR A HISTORY OF SEXUAL OFFENSES?

Yes. The operator of the camp must obtain a Sex

Offender Registry Informa on (SORI) report from the Massachuse s Sex Offender Registry Board (SORB) for all prospec ve camp staff, including any volunteers, and every three years for permanent employees with no break in service. The Sex Offender Registry Board is a public safety agency responsible for protec ng the public from sex offenders. The local health department will verify that SORI checks have been conducted during their annual licensing inspec on. For more informa on concerning the Sex Offender Registry Board, and SORI informa on and policies available to the public, visit the SORB website at ~~www.mass.gov/sorb~~.

HOW CAN I BE SURE THAT SUCH BACKGROUND CHECKS HAVE BEEN CONDUCTED?

You can request a copy of the camp's wri en policy on staff background checks from the camp director and ask the Board of Health to confirm that background checks were completed at the camp. Please note, however, that you are not authorized to review any staff person's actual CORI or SORI report.

IS THE CAMP REQUIRED TO HAVE A PERSON ON-SITE WHO KNOWS FIRST AID AND CPR?

Yes. All licensed camps are required to have a health care supervisor at the camp at all mes who is at least 18 years of age and is currently cer fied in first aid and CPR. The camp must provide backup for the health care supervisor from a Massachuse s licensed physician, physician assistant, or nurse prac oner who serves as a health care consultant. Medical specialty camps and residen al camps where there are a large number of campers and staff must have a licensed health care provider, such as a physician or nurse, on site.

HOW CAN I COORDINATE MY CHILD'S MEDICATION ADMINISTRATION WHILE AT A RECREATIONAL CAMP?

Parents or guardians must give approval for their child to receive any medica on at a recrea onal camp. Licensed camps are required to keep all medica ons in their original containers and to store all prescrip on medica ons in a secure manner. If your child will be par cipa ng in off-site ac vi es while taking prescrip on medica on, a second original pharmacy container must be provided to the camp. The only individual authorized to give your child his/her medica on is a licensed health care professional or the camp health care supervisor with oversight by the camp health care consultant. (Note that other arrangements may be made for emergency medica ons such as epinephrine auto-injectors and inhalers.) When your child's par cipa on at a camp ends, the medica on must be returned to you, if possible, or destroyed.

CAN A CAMP DISCIPLINE MY CHILD?

Yes. Camps are required to have a wri en disciplinary policy that explains their methods of appropriate discipline, for example, a ' me-out' from ac vi es or sending a child to the camp director's office. Under no circumstances, however, may a camper be subjected to corporal punishment such as spanking, be punished by withholding food or water, or subject to verbal abuse or humilia on.

WHAT STEPS DOES A CAMP HAVE TO TAKE TO PROTECT MY CHILD FROM ABUSE AND NEGLECT?

All licensed recrea onal camps must have policies and procedures in place to protect campers from abuse and neglect while at camp. You may ask a camp representa ve for specific informa on on the camp's policies and procedures for repor ng a suspected incident. In order to protect your child from possible abuse, you should talk openly and frequently with your child about how to stay safe around adults and other children.

WHAT STEPS CAN BE TAKEN TO HELP

PROTECT CHILDREN FROM MOSQUITO

AND TICKBORNE DISEASE SUCH AS

EASTERN EQUINE ENCEPHALITIS (EEE), WEST NILE VIRUS (WNV), AND LYME DISEASE?

Parents/guardians and camp administrators should discuss the need for repellent with campers and what repellent(s) may be available at the camp. Use of insect repellents that contain 30% or lower of DEET (N,Ndiethyl- m-toluamide) are widely available and are generally considered to be safe and effec ve for children (older than 2 months of age) when used as directed and certain precau ons are observed. These products should be applied based on the amount of me the camper spends outdoors and the length of me protec on is expected as specified on the product label.

Use of DEET products that combine repellent with sunscreen are not recommended, as over applica on of DEET can occur if sunscreens need to be applied more frequently. It is generally recommended to apply sunscreen first, then insect repellant.

Repellents containing DEET should only be applied to exposed skin, and children should be encouraged to cover skin with clothing when possible, par cularly for early morning and evening ac vi es when more mosquitoes are present. DEET products should not be applied near the eyes and mouth; applied over open cuts, wounds, or irritated skin; or applied on the hands of young children (the CDC recommends that adults apply repellents to young children). Skin where the repellent was applied should be washed with soap and water a er returning indoors and treated clothing should be washed before it is worn again. Spraying of repellents directly to the face, near other campers, or in enclosed areas should be avoided.

For More Information on Recreational Camps Please Follow the web link below:

For More Informa on

The Department has designed an additional document “Important Webpage Links regarding Recreational Camps for Children” to assist stakeholders with access to relevant information associated with Recreational Camps for Children. This document contains webpage links for related material and other points of interest.

Important Webpage Links.docx

Do not rely on glossy pictures and slick brochures when choosing a recreational camp for your child.

Contact the camp director to schedule an appointment for an informational meeting and tour of the facility prior to registering your child.

Ask the camp for a copy of its policies regarding staff background checks, as well as health care and disciplinary procedures. Ask to see a copy of the procedures for filing complaints with the camp.

Call the local health department/board in the city or town where the camp is located for information regarding inspections of the camp and to inquire about the camp’s license status.

Obtain names of other families who have sent their children to the camp, and contact them for an independent reference.

If you would like a copy of the state regula ons or addi onal informa on concerning

recrea onal camps for children, please visit www.mass.gov/dph/dcs or call the

Massachuse s Department of Public Health, Bureau for Environmental Health’s

Revised March 2018

THIS DOCUMENT INCLUDES IMPORTANT LINKS TO INFORMATION FOR RECREATIONAL CAMPS

The Massachusetts Department of Public Health (MDPH) has created this resource document to provide all stakeholders with easy access to relevant information associated with Recreational Camps for Children and compliance with 105 CMR 430.000: Minimum Standards for Recreational Camps for Children (State Sanitary Code, Chapter IV). It contains topic summaries with associated webpage links for related material based on the list of topics below. This is not a comprehensive list, but designed to assist those looking for additional information on relevant camp topics.

- **MEDICAL SAFETY**

    - Epinephrine Auto-Injector Guidance o "Heads Up" - Concussion Awareness o Immunizations o Influenza o Rabies o Swine Flu o Tuberculosis
    - West Nile Virus & Eastern Equine Encephalitis

- **OUTDOOR SAFETY**

o Bats o Beaches o Playground Handbook o DEET Insect Repellent ○ Extreme Heat Guidance ○ Security & Safety Plans

- **GENERAL REFERENCES**

- American Camp Association o Camp Administrator Training o Office of Public Safety and Inspections – Challenge Courses and Climbing Walls

- Medical & Biological Waste Management

Medical Safety:

- **Epinephrine Auto-Injector Guidance:**

Epinephrine auto-injector systems are used to deliver epinephrine through a syringe. The management (use and disposal) of this "acutely hazardous" substance is regulated in Massachusetts.

http://www.mass.gov/eea/docs/dep/recycle/laws/epifax.p df

http://www.mass.gov/eohhs/docs/dph/comhealth/school/epi-administration-reporting.pdf

- **Heads Up (Concussion Awareness):**

Health care professionals may describe a concussion as a "mild" brain injury because usually concussions are not life-threatening. Even so, their effects can be serious. Recognition and proper response to concussions, primarily when they first occur, can help prevent further injury or even death. This link provides information about sports-related head injury regulations, trainings (e.g. - "Heads Up"), required forms for schools and clinicians, model policies for schools, and other important details.

https://www.mass.gov/sports-related-concussions-andhead-injuries

- **Immunization:**

Vaccines are one of the great public health advances of the 20th century, and prevent hundreds of thousands of illnesses in the United States every year. Vaccines protect both the person vaccinated and those around them from serious diseases, a concept known as herd immunity. Herd immunity protects other members of the community, such as babies too young to be vaccinated or those who cannot receive immunizations because of a medical condition.

https://www.mass.gov/immunization-program https://www.cdc.gov/vaccines/index.html

https://www.mass.gov/service-details/vaccineinformation-for-the-public

http://www.mass.gov/eohhs/docs/dph/cdc/immunization/ guidelines-ma-school-requirements.pdf
http://www.mass.gov/eohhs/docs/dph/cdc/meningitis/inf o-waiver.pdf

- **Influenza:**

Influenza is a disease that primarily affects the respiratory system, including the nose, throat and lungs. “Flu” is short for “influenza”. Flu is caused by a virus and it can be very serious. Every year in the United States, seasonal flu causes thousands of hospital admissions and deaths. Getting an annual flu vaccine is the best protection.

https://www.mass.gov/influenza

- **Rabies:**

Rabies is a viral disease that can affect all mammals, including humans. The virus attacks the central nervous system and can be secreted in saliva. Because rabies affects people, as well as animals, control of this disease has become a top priority for the Massachusetts Division of Animal Health. With the cooperation of MDPH and the Massachusetts Division of Fisheries and Wildlife, all potential rabies exposures are investigated in order to prevent further rabies infections.

http://www.mass.gov/eohhs/gov/departments/dph/progra ms/id/epidemiology/providers/public-health-cdc-rabiesinfo-providers.html

- **Swine Flu:**

Swine flu is a respiratory disease associated with pigs caused by type A influenza viruses. Swine flu viruses do not normally infect humans. However, sporadic human infections with swine influenza viruses have occurred.

http://www.eec.state.ma.us/SwineFluUpdates.aspx

http://www.mass.gov/ocabr/docs/advisories/swineflu.pdf

- **Tuberculosis Program:**

The MDPH Tuberculosis Program seeks to reduce the incidence of tuberculosis (TB) through surveillance, education, and clinical services delivered within a collaborative multiagency system.

http://www.mass.gov/eohhs/gov/departments/dph/progra ms/id/tb/

- **West Nile Virus (WNV) and Eastern Equine Encephalitis (EEE):**

West Nile Virus (WNV) and Eastern Equine Encephalitis (EEE or “Triple E”) are viruses that can cause illness ranging from a mild fever to more serious disease like encephalitis or meningitis. They are spread to people through the bite of an infected mosquito. There are no specific treatments for either virus, but steps can be taken to protect from illness.

http://www.mass.gov/eohhs/docs/dph/cdc/factsheets/wnv

.pdf

http://www.mass.gov/eohhs/gov/departments/dph/progra ms/id/epidemiology/providers/public-health-cdcarbovirus-info.html

Outdoor Safety:

- **Bats:**

During the summer months, it is not unusual to find a bat in a building. Most often, these animals have accidently flown in and are now trapped. Bats sometimes carry rabies and may spread it to people or animals through bites or scratches, so it is important to remove bats from your building as soon as possible. If a person may have been bitten or scratched, it is important to capture the bat and have it tested for rabies.

http://www.mass.gov/eohhs/docs/dph/cdc/rabies/batcapturing.pdf https://www.mass.gov/service-details/bats-in-the-home

- **Beaches:**

Good water quality is essential to having a safe and enjoyable beach visit. It is important to monitor the water quality and report any potential water quality concerns. Each year, the Environmental Toxicology Program in MDPH, Bureau of Environmental Health collects water quality information related to fresh and saltwater beaches from local health departments, as well as the Massachusetts Department of Conservation and Recreation, and compiles a summarized report on the state of the beaches water quality.

http://www.mass.gov/eohhs/docs/dph/regs/105cmr445.p df

http://www.mass.gov/eohhs/gov/departments/dph/progra ms/environmental-health/exposure-topics/beaches-algae/ https://www.cdc.gov/nceh/hsb/cwh/technical_hab.htm https://www.epa.gov/nutrient-policydata/cyanobacterial-harmful-algal-blooms-water

- **Consumer Product Safety Commission Playground Handbook:**

Playgrounds have a number of potential hazards and maintaining safety is paramount to protecting children.

https://www.mass.gov/files/documents/2016/08/oi/famil y-child-care-playground-safety.pdf

https://www.cpsc.gov/safety-education/safetyguides/playgrounds https://www.cpsc.gov/s3fs-public/325.pdf

- **DEET/Repellent:**

Products with DEET (N,N-diethyl-m-toluamide) or permethrin are recommended for protection against ticks and mosquitoes. Some repellents, such as picaridin or oil of lemon eucalyptus, have been found to provide protection against mosquitoes but have not been shown to work against ticks.

http://www.mass.gov/eohhs/docs/dph/cdc/factsheets/su/tick-repellents.pdf

http://www.mass.gov/eohhs/docs/dph/cdc/factsheets/mo/mosquito-repellents.pdf

https://blog.mass.gov/blog/health/safe-practices-formosquito-and-tick-bites/

- **Extreme Heat:**

Heat related deaths and illnesses are preventable.

Despite this, an average of 618 people in the United States are killed by extreme heat every year. This website provides helpful tips, information, and resources to help you stay safe in the extreme heat during the summer.

https://www.cdc.gov/disasters/extremeheat/heat_guide.ht ml

- **Security:**

It is important to always be vigilant and mindful of the safety and security of the recreational camp. Some practices and useful information can be extracted from other related documents like the ones listed below:

A.L.I.C.E (Active Shooter Response Training):

A Guide for Developing High Quality School

Emergency / Operations Plans.

U.S. Department of Education (June 2013)

https://rems.ed.gov/docs/REMS_K-12_Guide_508.pdf

Massachusetts Task Force Report on School Safety and

Security (July 2014)

http://www.mass.gov/edu/docs/eoe/school-safetysecurity/school-safety-report.pdf

References:

- **American Camp Association-New England:**

http://www.acanewengland.org/

http://www.acanewengland.org/educationtraining/training-and-certification

- **Office of Public Safety and Inspections (OPSI):**

The Office of Public Safety and Inspections provides verification for licenses for challenge courses and climbing walls.

For More Informa on

http://www.mass.gov/ocabr/government/ocaagencies/dpl-lp/opsi/

• **Medical or Biological Waste Regulation – 105 CMR 480.000:** Management of the medical waste generated at recreational camps is governed by 105 CMR 480.000. Any and all generators of such waste must abide by the minimum standards noted in the document. In addition, web links to the required record keeping logs are provided to document the proper storage, transportation, treatment and disposal of any waste generated.

http://www.mass.gov/eohhs/docs/dph/regs/105cmr480.p df

http://www.mass.gov/eohhs/docs/dph/environmental/san

itation/105cmr480-medical-waste-off-site-log.pdf

http://www.mass.gov/eohhs/gov/departments/dph/progra ms/environmental-health/comm-sanitation/medicalwaste.html

If you would like a copy of the state regula ons or addi onal informa on concerning recrea onal camps for children, please visit www.mass.gov/dph/dcs or call the Massachuse s Department of Public Health Bureau for Environmental Health's Community Sanita on Program at 617-624-5757

Revised 2018

What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue (the “meninges”) that surrounds the brain and spinal cord and cause meningitis, or they may infect the blood or other organs of the body. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. In the US, about 350-550 people get meningococcal disease each year and 1015% die despite receiving antibiotic treatment. Of those who survive, about 10-20% may lose limbs, become hard of hearing or deaf, have problems with their nervous system, including long term neurologic problems, or have seizures or strokes. Less common presentations include pneumonia and arthritis. ***How is meningococcal disease spread?***

These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing and sneezing. ***Who is most at risk for getting meningococcal disease?***

People who travel to certain parts of the world where the disease is very common, microbiologists, people with HIV infection and those exposed to meningococcal disease during an outbreak are at risk for meningococcal disease. Children and adults with damaged or removed spleens or persistent complement component deficiency (an inherited immune disorder) are at risk. Adolescents, and people who live in certain settings such as college freshmen living in dormitories and military recruits are at greater risk of disease from some of the serotypes. ***Are camp attendees at increased risk for meningococcal disease?***

Children attending day or residential camps are **not** considered to be at an increased risk for meningococcal disease because of their participation. ***Is there a vaccine against meningococcal disease?***

Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra, Menveo and MenQuadfi) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease, for age 10 and older. ***Should my child or adolescent receive meningococcal vaccine?***

That depends. Meningococcal conjugate vaccine (MenACWY) is routinely recommended at age 11-12 years with a booster at age 16 and is required for school entry for grades 7 and 11. In addition, these vaccines may be recommended for additional children with certain high-risk health conditions, such as those described above.

Meningococcal serogroup B vaccine (Bexsero and Trumenba) is recommended for people with certain relatively rare high-risk health conditions (examples: persons with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited disorder), and people who may have been exposed during an outbreak). Adolescents and young adults (16 through 23 years of age) who do not have high risk conditions may be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection for most strains of serogroup B meningococcal disease. Parents of adolescents and children who are at higher risk of infection, because of certain medical conditions or other circumstances, should discuss vaccination with their child’s healthcare provider.

How can I protect my child or adolescent from getting meningococcal disease?

The best protection against meningococcal disease and many other infectious diseases is thorough and frequent handwashing, respiratory hygiene, and cough etiquette. Individuals should:

1. wash their hands often, especially after using the toilet and before eating or preparing food (hands should be washed with soap and water or an alcohol-based hand gel or rub may be used if hands are not visibly dirty);
2. cover their nose and mouth with a tissue when coughing or sneezing and discard the tissue in a trash can; or if they don't have a tissue, cough or sneeze into their upper sleeve.
3. not share food, drinks or eating utensils with other people, especially if they are ill.
4. contact their healthcare provider immediately if they have symptoms of meningococcal disease.

If your child is exposed to someone with meningococcal disease, antibiotics may be recommended to keep your child from getting sick.

You can obtain more information about meningococcal disease or vaccination from your healthcare provider, your local

Board of Health (listed in the phone book under government), or the Massachusetts Department of Public Health Divisions of Epidemiology and Immunization at (617) 983-6800 or on the MDPH website at https://www.mass.gov/infodetails/school-immunizations.

Provided by the Massachusetts Department of Public Health in accordance with M.G.L. c.111, s.219 and 105 CMR 430.157(C). Reviewed September 2022 Massachusetts Department of Public Health, Divisions of Epidemiology and Immunization, 305 South Street, Jamai ca Plain, MA 02130

The Commonwealth of Massachusetts

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Policy Statement Regarding Background Information Checks for

Staff and Volunteers at Recreational Camps for Children

The following information is intended to assist camp operators and boards of health in the interpretation of 105 CMR 430.090 regarding background checks for staff and volunteers at recreational camps for children. **Note**: No person can be employed or volunteer at a camp until the operator has obtained, reviewed and made a determination concerning all background information required at 105 CMR 430.090 (C) and (D) as summarized below.

Please note that the information contained in this document reflects the requirement of M.G.L. c. 6 §172G that camp operators obtain all available criminal offender record information and juvenile data as found in the court activity record for all prospective employees or volunteers prior to employment or volunteer service, and M.G.L. c. 6 §172 requirement that camp operators share this criminal offender record information with the government entities (e.g. - health agents) charged with overseeing, supervising, or regulating them.

The information given below is categorized by the residence of the prospective staff person as well as, volunteer. Follow the steps noted below to obtain background information for that person.

Staff Person - any individual employed by a recreational camp for children:

1. MA Resident

- Prior work history for previous five (5) years including, a name, address and phone number of a contact person at each place of employment.
- Three (3) positive reference checks from individuals not related to the staff person.
- Obtain criminal offender record information and juvenile report (CORI/Juvenile Report) from the Massachusetts Department of Criminal Justice Information Services (DCJIS).
- Sex offender registry information (SORI) check from the Massachusetts Sex Offender Registry Board (SORB).

2. Out of State Resident - Staff person whose permanent residence is outside MA

- Prior work history for previous five (5) years including, a name, address and phone number of a contact person at each place of employment. Three (3) positive reference checks from individuals not related to the staff person. Obtain CORI/Juvenile
- Report from the Massachusetts DCJIS. SORI check from the Massachusetts Sex Offender Registry Board.
- Obtain a criminal record check, or equivalent where practicable*, from the staff person's state of residence. Information
- can be obtained from the state's criminal information system, local chief of police, or other local authority with relevant
- information. Additionally, a national background check (e.g. - fingerprints) will also be acceptable. The availability and process for obtaining criminal history information from the other states can be found at http://www.mass.gov/eopss/crime-prev-personal-sfty/bkgd-check/cori/request-rec/requesting-outofstate-criminal-records.html.

3. International Resident - Staff person who currently lives outside of the United States

- Prior work history for previous five (5) years including a name, address and phone number of a contact person at each place of employment.
- Three (3) positive reference checks from individuals not related to the staff person.
- Obtain CORI/Juvenile Report from the Massachusetts DCJIS.
- Obtain a criminal record check, or equivalent where practicable*, from the staff person's country of residence. Information can be obtained from the country's criminal information system, local chief of police, or other local authority with relevant information.
- International staff(s) who have previously **been in the United States**: obtain a SORI check from the Massachusetts Sex Offender Registry Board.

Note on Permanent Staff: If there is no interruption in the staff person's employment by the camp or organization operating the camp from the time of the initial background check, **a new criminal or sex offender history is required at a minimum of every three years**. This applies only to permanent employees of the same camp/organization. Any break in employment service at any time during the year requires a new criminal history and SORI check for the staff person. An individual returning from one

summer to the next, but not employed during the year is not considered a permanent staff person; therefore the camp must complete new criminal history and SORI checks.

Note on Returning Staff: Returning staff may use references on record with the camp from the preceding year to satisfy the requirements of 105 CMR 430.090 (C) (noted as step B within the categories above). However, if there is a gap in employment with the camp for at least one camp season, new references shall be required.

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* *Where practicable means*, if the out of state or foreign jurisdiction notifies the camp in writing that no criminal background check or recognized equivalent is available from the jurisdiction, then the prospective staff person/volunteer, if s/he has completed all other requirements of 105 CMR 430.090, is deemed to be in compliance with 105 CMR 430.090. In addition, provided that the camp operator documents: (1) that s/he has timely requested the criminal history check from the appropriate jurisdiction (proof of mailing by certified mail) and that the requested authority failed to answer in writing; and (2) the completion of, at a minimum, all other requirements of 105 CMR 430.090; and (3) for international staff screened by an agency, a certification by the agency that a thorough background check was completed and that no criminal report from the staff person's local jurisdiction is available, then the prospective staff member, is deemed to be in compliance with 105 CMR 430.090.

Volunteers - any person who works in an unpaid capacity at a recreational camp for children:

1. All Volunteers

A. Prior work or volunteer history for previous five (5) years including a name, address and phone number of a contact person at each place of employment or place of volunteer service. B. Obtain CORI/Juvenile Report from the Massachusetts DCJIS.

C. SORI check from the Massachusetts Sex Offender Registry Board.

Criminal records and SORI checks must be kept separate from general camp paperwork and must only be accessed by individuals that are authorized to review it. If camps store the information at a location different from the camp, for example in a central office, the camp must arrange for the documents to be at the camp for the initial inspection for licensure. If the documents are not on site at the time of the inspection, it will be necessary for the camp to arrange another time for the inspector to review the documents.

If you have questions about the CORI or SORI check process, or about the information a camp receives from the DCJIS or SORB, please contact the appropriate agency below:

Department of Criminal Justice Information Services

617-660-4600

https://www.mass.gov/how-to/cori-forms-and-information.html

CAMPER RELEASE

.190 (B) Camper released only to Parents/Guardians or: Designated individual with Parent/Gua

authorization (~~electronic~~ or hard copy form) Authorized alternative arrangements

brookline tennis academy

Waiver and Health History Form (required for Summer Camp)

Camper Full Name

First Last

Check the week(s) of camp you will be attending

Early Week

Week 1

Week 2

Week 3

Week 4

Week 5

Week 6

Week 7

Week 8

Week 9

Week 10

Week 11

Week 12

Parent Full Name

First Last

Parent Email Address Parent Phone

Camper's Age

Camper's Sex Camper's Height

Camper's Date of Birth

Approved Pickup List

If applicable, please list the name and phone number of the individual(s) approved to pick up your child from camp.
MEDICAL CONCERNS/ ALLERGIES OF PLAYER (If none write "none" / if yes, please describe)

ADMINISTRATION OF MEDICATIONS (if applicable) - does your child need to take medication during the camp day? Yes No Not Applicable

IF MEDICATIONS ARE APPLICABLE, PLEASE GIVE DETAILS HERE

SUNSCREEN AND BUG SPRAY ADMINISTRATION - you consent to BTA Staff assisting your camper with sunscreen and/or bug spray application as needed Yes No Not Applicable

WAIVER / INDEMIFICATION

Parent(s) or legal guardian must sign below before player is accepted to participate in the Brookline /junior Tennis Academy: As parent/legal guardian of the child's name herein, I hereby represent that the child has been examined by a pediatrician and is physically fit to participate in the Brookline Tennis Junior Academy. I understand there are inherent risks in participating in this athletic program. I hereby accept responsibility for and agree to pay any and all costs of medical treatment resulting from any injury suffered by my child as a result of his/her participation at the Brookline Tennis Junior Academy. I further agree to indemnify and hold harmless The Roxbury Latin School, Brookline Tennis, its agents, servants, employees and/or representatives from any and all liability, damage, cost or expense arising out of my child's participation, of every kind and nature, at the Brookline Tennis Junior Academy. In the event that I cannot be reached in an emergency, I hereby give permission for care to be administered by a qualified staff member, emergency medical technician, physician/staff of a hospital, or any qualified individual to provide any medical treatment deemed necessary for my child.

eSignature by parent or legal guardian - By submitting this form you affirm you have read, understand and agree to the above Waiver/Indemnification.

Enter Your Full Name

Attach Your Child's Physician Form

Upload

Additional Comments/Information

Submit

Submit

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000

ADVISORY www.mass.gov/dph

To: Recrea onal Camp and Municipal Program Operators

From: Steven Hughes, Director, Community Sanita on Program (CSP), Bureau of Climate and Environmental Health

Date: June 14, 2024

Re: Extreme Heat-Related Illness and Preventa ve Measures for Recrea onal Camp and Municipal Program Operators

Many summer recrea onal camps for children and municipal programs offer outdoor ac vi es which involve strenuous physical exercise during the extreme heat and humidity. During high heat and humidity events, even young and healthy children can be at risk of heat-related illness. The Centers for Disease Control and Preven on (CDC) issued guidance on preven ng heat-related illness to protect individuals through preven on, iden fica on, and treatment. The

Massachuse s Department of Public Health's Bureau of Climate and Environmental Health (BCEH) offers recrea onal camp and municipal program operators this advisory to review, implement, and share preventa ve measures with their staff and volunteers.

The first step to mi ga ng risk is prepara on. The CDC, in partnership with the Na onal Oceanic and Atmospheric Administra on's (NOAA) Na onal Weather Service (NWS), has developed a ~~HeatRisk Dashboard~~ to provide a na onwide seven-day heat forecast model. This tool enables users to search by zip code, iden fy when air temperatures may reach levels that could nega vely impact their health, and provides recommenda ons on ac ons to be taken to safeguard their health during extreme heat events. This summer CSP will use this tool periodically to alert operators of predicted heat waves and to remind operators of regulatory requirements and best prac ces. CSP also encourages operators to use the tool for themselves to plan for major and extreme heat events.

The two most important tools to protect against heat-related illness is to maintain a low core body temperature and provide drinking water to stay hydrated. Regula on *105 CMR 430.000: Minimum Standards for Recrea onal Camps for Children (State Sanitary Code Chapter IV)*, sets forth minimum standards for housing, health, safety, and sanitary condi ons for minors a ending recrea onal camps for children in the Commonwealth. These requirements and suggested best prac ces iden fied below, provide an opportunity for recrea onal camp and municipal program operators to safeguard their campers, staff, and volunteers from heat-related illness:

- Educate campers and parents about the importance of hydra on. Send fact sheets home at the beginning of the season or before a predicted heat wave: o ~~Heat Stress: Hydra on (cdc.gov);~~ o ~~Estrés por calor: Hidratación (cdc.gov)~~;
- Create accessible fun cooling water sta ons during outdoor events (sprinklers, misters, etc.);
- Schedule water breaks frequently throughout the day in shaded or indoor areas;
- Provide ar ficial shaded areas with canopies or tents, when natural shade is not available; • Provide ice as needed;
- Reschedule outdoor ac vi es to the coolest part of the day, like the morning and evening hours;
- Increase ven la on to sleeping and assembly areas, provide fans if possible;
- Ensure windows that get late morning and/or a ernoon sun are covered or nted; • Encourage everyone to wear clothing to keep cooler and protect from the sun: o Light-colored and loose-fi ng clothing helps to reflect heat and promote airflow; o Hats or light scarfs protect the head, neck and face from sun exposure;
- Use sunscreen - **~~always~~**;
- pInecrrmeai seed a bcecaecshs etos asnafde s rweicmrema ionnga pl osowlism thmaitn ceo or nvlva twerit rhe appropriate safety measures in place such as lifeguards, trained staff, and safety equipment;
  - Ensure there is sufficient natural or ar ficial shade available for those children and staff wai ng in line to enter the swimming area, or for those children and staff who are not swimming;
  - Plan ahead to ensure there is an appropriate number of lifeguards overseeing the water, during expected high volume use, when swimming is offered during extreme heat:
    - Use other staff to monitor pool decks on high heat/high volume days;
    - Ensure there is enough disinfec on and treatment chemicals available to maintain a safe and healthy pool during opera on and a er (for shocking procedures);
    - Conduct water tes ng more frequently than the minimum 4 mes a day to maintain the disinfec on level during and a er high use and excessive UV (sun) which both affect pool chemistry;
- Train on-site Health Care Supervisors and other camp staff/volunteers on the signs, symptoms, and increased risk factors for heat-related illness (e.g. obesity, asthma, and medica on use);
- Implement a buddy system for observing fellow staff/volunteers for early signs and symptoms of heatrelated illness;

rn o Provide swimming only at and clarity standards and have

- Iden fy priority loca ons in cooler areas to be made available for heat sensi ve, at-risk, or new campers and staff/volunteers who may not be acclimated to extreme heat condi ons; and
- Camps that provide sport related ac vi es should take addi onal precau ons to schedule ac vi es and rest breaks to protect their young athletes. Refer to the Massachuse s Interscholas c Athle c Associa on (MIAA) Heat Modifica on Policy.

Listed below are further details on the signs and symptoms of the different types of heat-related illness, and what you should do if you see someone in distress from the heat. When in doubt, call 911 or emergency medical services.

Addi onal informa on is available at: h ps://www.cdc.gov/disasters/extremeheat/warning.html

Signs of Heat Cramps	You Should	Go to the Hospital if:
• Heavy swea ng • Muscle pain or spasms (o en in the abdomen, arms, or calves)	***Give them water, clear juice, or a sports drink*** • Tell them to stop exer ng themselves and/or stop physical ac vity and move to a cool place Have them wait for cramps to go away before doing any more physical ac vity	• The person has a history of heart problems • Cramps last longer than 1 hour The person is on a low sodium diet
Signs of Heat Exhaus on	**You Should:**	**Go to the Hospital if:**
Lots of swea ng Fast/weak pulse Nausea/vomi ng Headache/dizziness Fain ng (passing out) Muscle cramps • Cold, pale, and clammy skin Fa gue/ redness/or weakness Irritability Thirst Decreased urine output	***Give them water*** Move them to a cool place Allow them to lie down • Loosen their clothes or change into lightweight clothing Apply cool wet towels or cloths on the person	The person is throwing up The person is ge ng worse Symptoms last longer than 1 hour • The person has heart problems or high blood pressure
Signs of Heat Stroke	**You Should:**	
Fast, strong pulse High body temperature (above 103°F) Confusion Dizziness • Red, hot, dry, or damp skin	**CALL 911 – this is a medical emergency** • Reduce the person's body temperature with whatever means you can - apply cool wet towels or cloths on the person, immerse them in a cool bath/shower, or spray	

• Throbbing headache Nausea Losing consciousness (passing out) Altered mental state Unconsciousness	• them with cool hose water Move them to a cool place • Wait un l clearance from a medical professional BEFORE you give them anything to drink If there is uncontrollable muscle twitching, keep the person safe, but • do not place any objects in their mouth • If there is vomi ng, turn the person on their side to keep the airway open	

The Department of Public Health's Community Sanita on Program recommends this informa on be shared with all recrea onal camp or program staff and volunteers, including the on-site Health Care Supervisor(s). As always, thank you for your coopera on and assistance with this important public health ma er.

Boater Safety Education Certificate **issued by MA; and**

Oral Liquid *Drops: eye, ears, nose* *Topical*

Camper's School Camper's Grade **Person to Notify in Case of Emergency Phone Number of Emergency Contact**