brookline
tennis
academy

FAMILY HANDBOOK

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CONTACT US

Camp Location:
The Roxbury Latin Tennis Courts
101 Saint Theresa Ave
West Roxbury, MA 02132
Please check the directions to the tennis courts below under Arrival

Main Phone Number: 617-283-9812

Absence Reporting: 617-283-9812

Fax Number: N/A

Director: SHELLY MARS

Assistant Director: RODRIGO MENDEZ

Registrar: SHELLY MARS

Nurse: Mrs. Keri Maguire - keri_maguire@roxburylatin.org

IMPORTANT DATES, HOURS AND EVENTS

PROGRAM DATES & HOURS: Tennis
Camp weekly dates for 2025:

WEEK 1 - June 2-6	WEEK 7 - July 14-18
WEEK 2 - June 9-13	WEEK 8 - July 21-25
WEEK 3 - June 16-20	WEEK 9 - July 28-August 1
WEEK 4 - June 23-27	WEEK 10 - August 4-8
WEEK 5 - June 30-July 3 (NO CAMP July 4)	WEEK 11 - August 11-15
WEEK 6 - July 7-11	WEEK 12 - August 18-22

WEEK 13 August 25-29

Sign-Up Options:

- 9-12 HALF DAY
- 9-3 FULL DAY
- Early Drop at 8 am
- Extended Day 4pm pick up

Please view the following important Arrival and Dismissal Procedure Updates.

ARRIVAL

New -Arrival

We ask all families to please keep their child(ren) home if they are sick and are not feeling well.

Families are permitted to drop off anytime between 8:45-8:55am camp starts promptly at 9:00am. Upon arrival, families will park at Rappaport Parking on campus, there are bathrooms located at the far end of Rappaport parking to wash hands, use bathroom facilities, put sunscreen on camper, assemble campers' bag to include: extra sunscreen, lunch, snack, water bottles, tennis racquet, hat, and any additional items that the parent deems necessary for their child. Parents should pack all lunches and snacks in cold pack containers. Parents will walk their campers to the tennis courts. Counselors will be eagerly greeting and escorting campers to their designated courts between 8:45-8:55 am.

Arrival Notes

- **Directions to the tennis courts** - Take St. Theresa Ave to the end (go past the main entrance to RL) and make right hand turn onto Quail Street, once on Quail Street, look for signs on left to Rappaport parking/tennis courts on your left, make left turn into Rappaport Parking, go far end of lot to use bathroom facilities, apply sunscreen, and assemble campers' bag for the day. Walk campers to the tennis courts, and you will then be greeted by a staff member to direct you to tennis court assignment and coach.

- **Drop-Off** - Rain free days at Rappaport parking lot (#1 parking area shown on website) and rainy days at The Gordon Field House, entrance called Centre Street entrance, using the school house parking area #2 shown on map from website: www.brooklinetennis.com.
- **Late Arrival** - If your child will be arriving late, please call Shelly Mars in advance at 617-283-9812. Once on site, please walk your camper to their coach located at the tennis courts.

DISMISSAL

Dismissal

- Half Day 12:00 pm
- Full Day 3:00 pm
- Extended Day 4:00 pm

- **Parking** - is located at Rappaport Parking lot off Quail Street on rain free days. School House parking on rainy days.

- **Directions to Rappaport Parking** - Take St. Theresa Ave to the end (go past the main entrance to RL) and make a right-hand turn onto Quail Street, once on Quail Street, look for signs on the left to Rappaport parking/tennis courts on your left, make left turn into Rappaport Parking.

- **PICK UP** - Pick up for 12, 3pm and 4pm dismissal times at the tennis courts. Please Park in the parking lot and come to the tennis courts to pick up your camper.

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- **Early Dismissal** - If your child needs to be picked up early, please call Shelly Mars in advance, 617-2839812. Please come to the tennis courts to pick up your child.

- Rain free days at Rappaport parking lot (#1 parking area shown on website) and rainy days at The Gordon Field House, entrance called Centre Street entrance, using the School House parking area #2 shown on map from website: www.brooklinetennis.com.

- **If your child is to go home with anyone other than an authorized person, written documentation is required. Release authorization forms can be found under camp forms. www.brooklinetennis.com/alt-pickup-form**

WHAT TO BRING

Please label all items with your child's full name!

- **Campers should dress appropriately for the days weather and for tennis • Sneakers**
- **Backpack or bag for keeping… o Face mask (optional for indoor play) o Light jacket o *Packed**

Nut Free Lunch and two snacks (M-F) with cold packs. o **Change of clothes if needed.**

- o **Small towel** o **Tennis Racquet** o **Sunscreen - 1st application should be applied before coming to camp**
- o **Hat**
- o **Water Bottle**

- **Use care when bringing in any personal items such as cell phones, toys, and/or collectibles such as trading cards.**

Although the camp is not responsible for any lost items, we will do our best to return labeled items and to keep track of "forgotten" items in our lost and found area. We will encourage our staff to check the lost and found area frequently.

SUNSCREEN PROTECTION

We encourage families to help/remind their campers to arrive each morning with an initial application of sunscreen. Campers should also bring their own preferred sunscreen to be reapplied later in the day. Staff will remind and allow campers time to reapply sunscreen as needed. Please note that each group will have sunscreen (50+) available for campers and staff who have run out and/or who have forgotten to bring their own sunscreen.

Campers Age 4-6

Counselors working with these age groups will help campers reapply sunscreen as long as the parent/guardian has indicated permission on the Campers registration Form for our staff to do so. Reapplication of sunscreen will take place after snack break (11:00am) and after lunch (1:00pm).

Campers Age 7+

Campers in Grade 2 and up will be reminded to apply their own sunscreen following snack break (11:00 am) and after lunch (1:00pm).

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.

Using Insect Repellents Safely and Effectively

LUNCH & SNACK

Nut Free Campus – We aim to provide a safe and inclusive environment for all. Although we recognize there are students with a variety of allergies, peanut/nut allergies are most prevalent, and they are particularly severe; ingesting even a small amount can cause a life-threatening reaction for some children, and avoiding the allergen is the only way to prevent the allergic (and potentially lethal) reaction. As a result, BTA will adopt the following "Nut Free" policy: We do not allow peanut or tree nut items anywhere on campus, tennis courts and lunch area. This means that all campers and staff will not be permitted to bring in any peanut or tree nut food items. We ask families to check labels on all pre-packaged foods like granola bars, as many of these products contain nuts. Your efforts are truly appreciated, and are essential to our success in safeguarding against a potentially serious and regrettable incident. We know it is easy to forget when you are not directly affected, so we will continue to provide helpful reminders.

Lunches and Snacks – All parents are required to pack snacks and lunches for their children in lunch boxes with cold packs.

If a camper arrives without a snack and lunch, Shelly Mars will tell parent at drop off that they need to return with a snack and lunch for their child. If for any reason the parent does not return, BTA will provide lunch and snack for camper. Extra water bottles will always be stored in the shed next to the tennis courts in case camper arrives without a water bottle.

HEALTH & SAFETY

We have a registered nurse on campus and on duty during regular camp hours, and a hired Physician (Healthcare Consultant) on call. If your child has any medical concerns that you would like to share with the doctor, please send an initial email to **Nina Diggs,RN** at Nina.diggs@gmail.comto schedule a follow-up phone call and/or appointment.

Health Forms

Mandatory: Forms must be on file before a child can attend camp.

Health History is to be submitted by a parent/guardian electronically.
Physical Exam/Immunizations from a physician. This form must include the most recent physical exam date (on or after 7/1/23) and immunizations.
For additional information regarding immunization schedule visit-Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
EUA Advice-Information Request (fda.gov)

Emergency Contact Information

For the safety of the children, it is very important that the emergency contact information you provided is accurate. In the event that we are not able to reach a parent/guardian, we need to have alternate numbers of relatives, friends and/or neighbors. Please review the information entered into your registration and notify us in writing if there are any changes.

Health Policies and Communication
In the event a camper is feeling ill, has suffered an injury or needs to seek additional medical evaluation, Shelly Mars will notify families via phone. Examples may include; a bump to the head, infectious disease, Cold or COVID-19 symptoms, headache, bathroom accident. Additionally, families will be notified if a camper does not have lunch. An alternate (nut free) lunch will be provided if the family is unable to provide one.

Find your local DCF location • https://www.mass.gov/orgs/massachusetts-department-of-childrenfamilies/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

Infectious Diseases
Children who show signs of infectious disease and/or parasites must be kept home until the risk of contagion has passed. This specifically means that the child should be without fever for 24 hours and if antibiotics have been prescribed, on the medication for 24 hours before returning to camp. Any occurrence of parasites must be reported to the camp so that control measures can be taken. Children with parasites may not attend camp.

Injury Form: https://redcap.ehs.mass.gov/redcap/surveys/?s=LY94XWXRYWLFLCFR

Medication Administration

- Submit an **Authorization to Administer Medication Form** via website when registering (under medical forms, waiver and health history for summer camp)
- Bring medication in the **ORIGINAL PRESCRIPTION CONTAINER** and give directly to the camp director, Shelly Mars (please do not give medication to counselors or any staff other than the camp director).
- ***IMPORTANT***: Campers are not allowed to carry and administer their own medic

Toilet Training Policy

Campers must be toilet trained before starting camp; wearing pull-ups is not permitted. During this developmental stage, we aim to work collaboratively with families, and to provide assistance. Bathroom breaks and routines are 8 established. Campers having multiple accidents in a single week may be asked to delay camp participation; refunds and/or credits will be furnished.

Camper Dismissal

The Brookline Tennis Academy staff reserves the right to withdraw any camper when, in the director's judgment, the camper's or family's behavior interferes with the rights and/or safety of others or themselves, the smooth functioning of the program, or violates any of the camp policies outlined in this handbook.

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
Meningococcal **Grade 11–12‡**	weeks after the previous dose; 1 dose is acceptable if it was given on or after the 16th birthday. 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)
[illegible]	[illegible]	[illegible]
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
		Infanrix
HDiapehmthoeprhiail,u tse t*inafnluuse,n azande* taycpeell ubl vaar cpceirmtuasis vaccine	Hiibb B ((PPRRPP--OTMP)	ActHIB
		Hiberix
	HepA	PedvaxHIB
	HepB	Havrix
Hepatitis A vaccine	HPV	Vaqta
Hepatitis B vaccine	IIV3	Engerix-B
	ccIIV3	Recombivax HB
Human papillomavirus vaccine	LAIV3	Gardasil 9
Influenza vaccine (inactivated: egg-based)	MMR	Multiple
Influenza vaccine (inactivated: cell-culture)	MenACWY-CRM	Flucelvax
Influenza vaccine (live, attenuated)	MenACWY-TT	FluMist
Measles, mumps, and rubella vaccine	MenB-4C	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenB-FHbp	Priorix
Meningococcal serogroup B vaccine	MenACWY-TT/ MenB-FHbp	Menveo
		MenQuadfi
Meningococcal serogroup A, B, C, W, Y vaccine	Mpox	Bexsero
Mpox vaccine	PCV15	Trumenba
P	PCV20	Penbraya
Poliovirus vaccine (inactivated)	PPSV23	Jynneos
Pnneeuummoococcccaall pcoonlyjusagcacteh avraidccei nveaccine	IPV	Vaxneuvance
Respiratory syncytial virus vaccine	RSV	Prevnar 20
Rotavirus vaccine	RV1	Pneumovax 23
Tetanus, diphtheria, and acellular pertussis vaccine	RV5	Ipol
	Tdap	Abrysvo
Tetanus and diphtheria vaccine	Td	Rotarix
Varicella vaccine	VAR	RotaTeq
		Adacel
		Boostrix
		Tenivac
		Tdvax
		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/

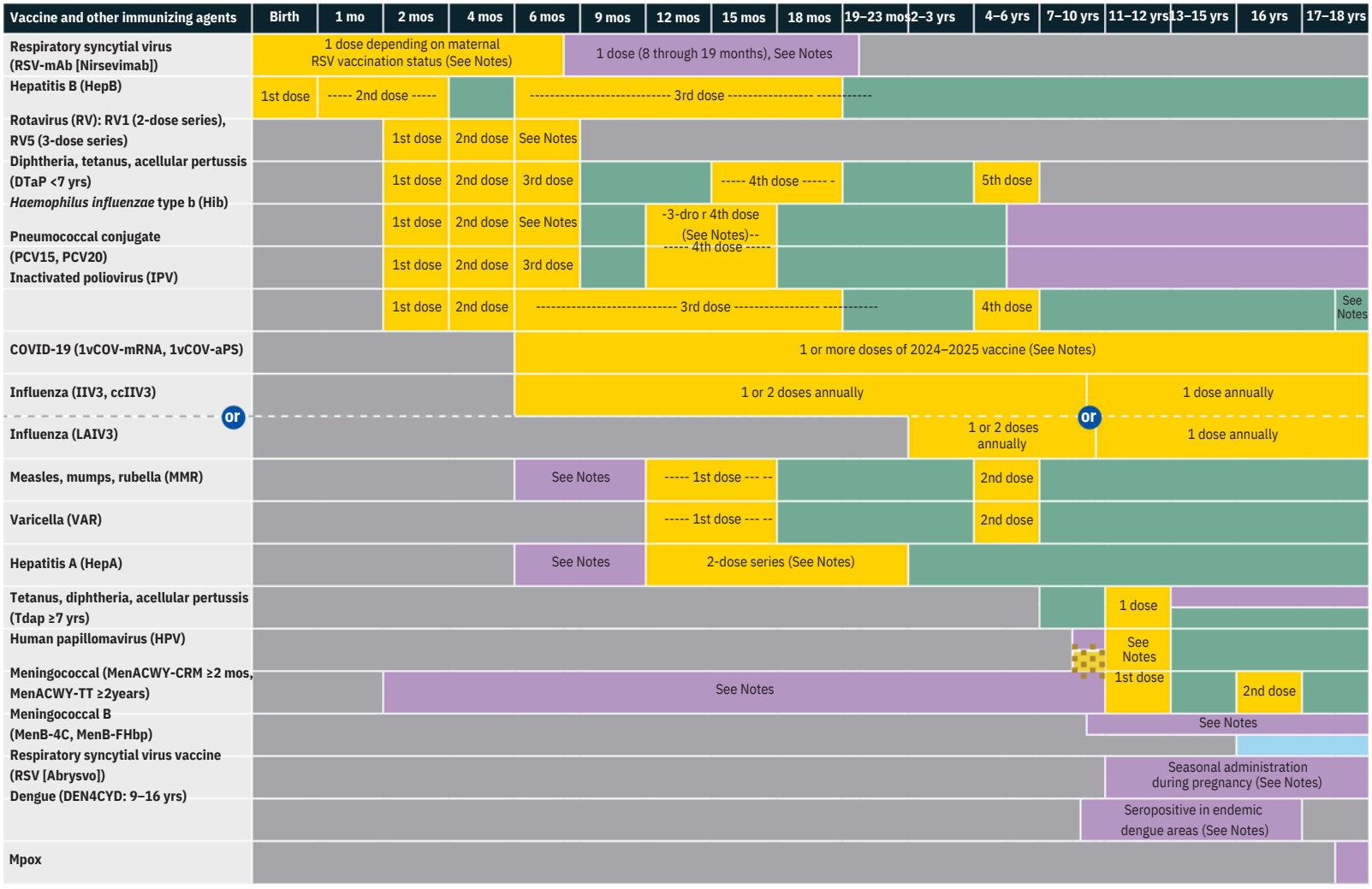
Scan QR code for access to online schedule

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).



Routine recommendation for all children/adolescents in this age group

Catch-up vaccination for children/adolescents who missed vaccines in earlier age groups

Range of recommended ages for all children/adolescents in this age group and catch-up for children/adolescents who missed vaccines in earlier age groups

Recommended vaccination can be administered based on shared clinical decision-making

Recommended vaccination based on shared clinical decision-making

No Guidance/ Not Applicable

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 was 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	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

y For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.

y Within a number range (e.g., 12–18), a dash (–) should be read as "through."

y 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.

y Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.

y 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).

y For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.

y 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.

y **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

y **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.

y **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

y **Unvaccinated:** 1 dose 2024–25 Moderna or Pfizer-BioNTech

y **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

y **Unvaccinated:**
- 1 dose 2024–25 Moderna or Pfizer-BioNTech
- 2 doses 2024–25 Novavax at 0, 3–8 weeks

y **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*)**.*

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 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.*

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 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.*

COVID-19 vaccination - continued

- **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

- 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
- 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
- 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

- 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

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **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.
- **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

- **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.
- **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)
- **American Indian and Alaska Native infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

- **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).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **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.
- **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.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **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 w w w.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

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.

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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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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

- **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

- **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
- **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

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

Catch-up vaccination with PCV

- Healthy children aged 2–4 years with any incomplete* PCV series: 1 dose PCV
- 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

- 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)
- 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

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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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)
- ePaarrelgy npaanrtc yo:f 1ge dsotastei oTndaalp w deuerkinsg 2 e7a-r-l2y6 pregnancy, preferably in

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*
- (Dao doses 2e minadayd rbeer taednmtliyn aisdtemriendis ates reeadr layf taesr 3a tm leoanstth 4s awfteeerk dso msea y1 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 • Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine
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	• Horis tteotrayn oufs A-trothxouisd-–tycpoen thayinpienrgs evnascictiinviet;y d reefaecrt ivoancsc ianfatetiro 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 • Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)
Measles, mumps, rubella (MMR)	• 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	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • 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
Measles, mumps, rubella, and varicella (MMRV)		
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	• For MenACWY-CRM only: Preterm birth if younger than age 9 months • 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 • 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 component3	• Moderate or severe acute illness with or without fever • Moderate or severe acute illness with or without fever • 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 component5	• 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	• Chronic gastrointestinal disease
Rotavirus (RV) RV1 [Rotarix] RV5 [RotaTeq]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • 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)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• 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 • Moderate or severe acute illness with or without fever • Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)
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	• Use of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination through 14 days after vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • 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. Whenever a precaution is present, 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. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/precautions.html.
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.

Addendum

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

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines	Recommendations	Effective Date of Recommendation*
No new vaccines or vaccine recommendations to report		

*The effective date is the date when the CDC director adopted the recommendation and when the ACIP recommendation became official.

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

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Advisory regarding the Parent/Guardian Authorization to 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 require any medication during their time at camp, Massachusetts regulations (105 CMR 430.000: *Minimum Standards for Recreational Camps for Children* (State Sanitary Code, Chapter IV)) require the camp to follow certain procedures to ensure minimum safety requirements are met

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 specific 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.**

o Specify "NA" – Not Applicable, where appropriate.

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

_____

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 <u>insulin dependent</u>**, 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 <u>epinephrine</u>**

  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.

POLICIES AND PROCEDURES

Please note: Families also have the right to review camp policies and procedures regarding staff background checks, health screenings and care, discipline, and grievances upon request.

***All BTA staff undergo annual training, which includes Staff Training, CDC's Head's Up Concussion training and First Aid Procedures.**

Recreational camps for children - Community Sanitation

Brookline Tennis Academy Master Policy_

Brookline Tennis Academy Healthcare Policy_

Grievance Policy

If a child, coach, or other camper involved with Brookline tennis Academy summer camp has a concern or grievance related to the operation of BTA'S program, staff, or policies, he or she should bring that concern

first to the camp director, and secondly to the Director of Summer Camp programs at the Roxbury Latin School.

IMPORTANT: Any grievance involving an alleged violation of state of federal law will be reported to, and investigated by the proper authorities.

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

(name of camper)

430.160(C) and 105 CMR 430.160(D) [see below].

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 use. **(M.G.L. c. 94C § 21).**

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 be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D): A written policy for the administration of medications at the camp shall identify the 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 pre-existing 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 and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

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.

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 450.160(I)(2).

Staff Information:

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 reaction.	
Describe allergy management and exposure prevention for campers with a known allergy.	
Describe the proper emergency action to be taken in response to cases of severe allergic reaction: • steps to follow; • when to call 911; and • notification 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 Auto-Injectors

Every health care supervisor (HCS) shall complete a training and a test of competency on administration of epinephrine auto-injectors under the direction of the health care consultant. 1 However, due to the emergent nature of anaphylactic reactions, other staff may also be trained in the administration of an epinephrine autoinjector under the direction of the health care consultant. The parent/guardian and the health care consultant must have given written informed consent for unlicensed staff to administer an epinephrine auto-injector. The parent/guardian authorization should also contain a separate approval for self-administration by the camper, if applicable.

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

1. Confidentiality
2. Understanding Allergic Reactions and the Signs of Anaphylaxis
    - Mild versus Severe Allergic Reaction Symptoms
3. Allergy Management and Exposure Prevention for Campers with a Diagnosed Allergy
4. Emergency Action Plan for Anaphylaxis
5. Proper Use of an Epinephrine Auto-Injector
6. Documentation and Record-keeping

Test of Competency: Each health care supervisor, and other staff, who are trained in the administration of epinephrine auto-injectors under the direction 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 reaction.
4. Describe allergy management and exposure prevention for campers with a known allergy.
5. Describe the proper emergency action to be taken in response to cases of severe allergic reaction:
    - steps to follow;
    - when to call 911; and
    - notification 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.

[1] If HCS is a Massachusetts licensed physician, nurse or physician's assistant, that certification is evidence of proper training and competency.

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).

Staff Information:

Health Care Supervisor's Name: _____

Date of Assessment: _____

Medication Name(s):

❑ See attached list

_____

Route:

□Oral Liquid □Drops: eye, ears, nose □Topical □Oral Tablet

Checklist	
Steps to Follow:	**Check (√)**
Demonstrate safe handling and proper storage of medication.	
Demonstrate the ability to administer medication properly: • accurately read and interpret the medication label; • follow the directions on the medication label correctly; and • accurately identify the camper for whom the medication is ordered.	
Demonstrate the appropriate and correct record keeping regarding medications given and/or self-administered.	
Demonstrate correct and accurate notations on the record if medications are not taken/given either by refusal or omission and when adverse reactions occur.	
Describe the proper action to be taken if any error is made in medication administration or if there is an adverse reaction possibly related to medication.	
Use resources appropriately, including the consultant, parent/guardian or emergency services when problems arise including: • steps to follow; • when to call 911; • notification of parent/guardian and health care consultant; and • appropriate procedures that assure confidentiality.	
Comments:	

Signatures:

Health Care Consultant

Name and Title:

_____

Signature:

_____

Date

Health Care Supervisor

Signature:

_____

Date

DPH Standards for Training Health Care Supervisor in Medication Administration

Each recreational 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.2 This training does not need to be submitted for prior approval but must be made available by request or during an inspection.

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

1. Confidentiality
2. The Role of the Health Care Supervisor
3. Limits of the Health Care Supervisor
4. Effects and Possible Side Effects of all Medication Administered
5. Steps in Medication Administration 6. Camp Safeguards and Policies

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

1. Demonstrate safe handling and proper storage of medication.
2. Demonstrate the ability to administer medication properly:
   - accurately read and interpret the medication label;
   - follow the directions on the medication label correctly; and
   - accurately identify the camper for whom the medication is ordered.
3. Demonstrate the appropriate and correct record keeping regarding medications given and/or self-administered.
4. Demonstrate correct and accurate notations on the record if medications are not taken/given either by refusal or omission and when adverse reactions occur.
5. Describe the proper action to be taken if any error is made in medication administration or if there is an adverse reaction possibly related to medication.
7. Use resources appropriately, including the health care consultant, parent/guardian or emergency services when problems arise.
8. Understand and be able to implement:
   - emergency plans including when to call 911; and •
   - appropriate procedures that assure confidentiality.

[2] If HCS is a Massachusetts licensed physician, nurse, or physician's assistant, that certification is evidence of proper training and competency.

1. Confidentiality:		
	Importance of not sharing information about campers or medications with anyone unless directed to do so by the HCC	
2. Role of Health Care Supervisor:		
	Administer Medication only by Specific HCC Order to Specific Child	
	Follow Instructions on Medication Sheet	
	Record Time and Effects Observed	
	Reports Any Problem or Uncertainty	
3. Limits of the Health Care Supervisor:		
	HCS may not administer ANY medication without HCC approval	
	HCS may not administer ANY medication without parent/guardian permission	
	HCS may not administer insulin (unless within scope of practice or in accordance with 105 CMR 430.160(G))	
4. Effects and Possible Side Effects of all Medication Administered:		
	Describe Effects of Medications	
	Discuss Common Side-Effects of Medications (drowsiness, vomiting, allergic reaction)	
	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 Medication Administration:		
5 Rights of Medication Administration	1. Right Camper 2. Right Medication 3. Right Dosage 4. Right Time 5. Right Route	
Steps in Medication Administration	1. Identify Camper 2. Read Medication Administration Sheet 3. Wash Hands 4. Select and Read Label of Medication 5. Prepare Medication and Read Label Again 6. Administer Medication and Make Sure Medication is Taken. 7. Replace Medication in Secure Location 8. Lock or Secure Location 9. Document in Medication Log	
Steps in Supervising Self-Administration	1. Identify Camper 2. Read Medication Administration Sheet 4. Select and Read Label of Medication 5. Observe Student Prepare and Take Medication 6. Replace Medication in Secure Location 7. Lock or Secure Location 8. Document in Medication Log	
6. Camp Safeguards and Policies		

	Report Any Error to HCC and Parent/Guardian including: 1. Camper Given Wrong/Unapproved Medication 2. Camper Refuses Medication 3. Camper Has Unusual or Adverse Reaction Possibly Related to Medication	
	Review Camp's Emergency Plan and when to call Emergency Services	

Camp Medication Administration Training Checklist:

✓

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 Practitioner		
Address City: Additional Contact Information Phone:	State:	Zip Code:
Email:		
Fax:		

I, _____, acknowledge that I serve as the Health
(Print Name)
Care Consultant for _____.
(Camp Name)

As such, I hereby authorize the **list of attached** medications to be administered to campers as prescribed, provided that, the medications are delivered to the camp, maintained by the camp, and administered in accordance with Commonwealth of Massachusetts Regulations 105 CMR 430.160 and that the parent/guardian of the camper has provided written permission for the administration of the medication.

I am not the prescribing physician for these medications. My signature indicates only that I have reviewed the attached list of medications and associated potential side effects, adverse reactions and other pertinent information with all personnel listed below, who administer medications 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 medications at camp:

_____

_____

_____

_____

_____

Signature: _____

Date: _____

Below are the prescription medications reviewed by the Health Care Consultant to be administered at

_____ by individuals authorized to administer medications 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 multiple copies of this page if additional medications are administered at camp.**

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
    - o 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.
- 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.

Disease Outbreak Preparedness and Response Plan for Camp

1. Introduction

The health and safety of all camp participants are of paramount importance. This plan outlines the procedures to prepare for and respond to disease outbreaks, ensuring minimal disruption and effective management.

2. Preparation Phase

2.1. Staff Training and Education

- **Regular Training**: Conduct regular training sessions for all staff on recognizing symptoms of common infectious diseases, hygiene practices, and outbreak response protocols.
- **Certification**: Ensure that at least one staff member is certified in infectious disease control and first aid.

2.2. Health Screening

-**Pre-Camp Screening**: Require all campers and staff to complete a health screening questionnaire and provide a recent medical examination report prior to arrival.

- **Daily Health Checks**: Implement daily health checks, including temperature checks and symptom monitoring for all participants.

2.3. Hygiene and Sanitation

- **Hygiene Stations**: Install handwashing stations and hand sanitizers at key locations around the camp.
- **Cleaning Protocols**: Establish and enforce rigorous cleaning and disinfecting protocols for all camp facilities, especially high-touch surfaces. 3.
  Response Phase

3.1. Identifying an Outbreak

- **Symptom Monitoring**: Staff should be vigilant in monitoring campers for symptoms of illness, such as fever, cough, sore throat, gastrointestinal distress, and rash.
- **Reporting**: Any staff member or camper showing symptoms should report immediately to the camp health officer.

3.2. Immediate Response

- **Isolation**: Symptomatic individuals should be immediately isolated in a designated isolation space.
- **Medical Assessment**: The camp health officer should perform an initial assessment and, if necessary, arrange for medical evaluation.

3.3. Disease Containment

3.3.1. Isolation and Quarantine Spaces

- **Isolation Space**: Designate and prepare an area specifically for isolating individuals who show symptoms of illness. This space should be wellventilated and equipped with necessary medical supplies.
- **Quarantine Space**: Have a separate area for those who have been exposed to a symptomatic individual but are not yet showing symptoms. This helps prevent potential spread while monitoring for signs of illness.

3.3.2. Staffing Plans

- **Alternative Staffing**: Develop a contingency plan for staffing in the event that primary staff members become ill. This could include: - **On-call Staff**: Maintaining a list of on-call staff who can be brought in on short notice.
- **Cross-Training**: Ensuring that staff are cross-trained to cover essential functions.
- **Remote Support**: Implementing remote support for administrative tasks where feasible.

4. Reporting Requirements

4.1. Internal Reporting

- **Incident Log**: Maintain a detailed log of any illness incidents, including symptoms, affected individuals, isolation measures taken, and outcomes. **Daily Updates**: Provide daily updates to the camp director on the status of any isolated or quarantined individuals.

4.2. External Reporting

- **Health Authorities**: Notify local public health authorities of any confirmed cases of reportable diseases as per local regulations.
- **Parent/Guardian Communication**: Inform parents or guardians of any significant health incidents, while maintaining confidentiality as required by law.

5. Communication Plan

- **Internal Communication**: Ensure clear and timely communication among camp staff regarding outbreak status and response actions. - **External Communication**: Prepare templates for communicating with parents, guardians, and health authorities.

6. Post-Outbreak Review

- **Debriefing**: Conduct a debriefing session with all staff to review the response to the outbreak and identify areas for improvement.
- **Report**: Compile a detailed report on the outbreak response, including what was effective and what could be improved for future preparedness.

7. Continuous Improvement

- **Regular Drills**: Conduct regular drills to practice outbreak response procedures.
- **Feedback Mechanism**: Establish a system for collecting and incorporating feedback from staff, campers, and parents on health and safety practices.

By following these procedures, the camp can ensure a swift and effective response to any disease outbreak, minimizing its impact on campers and staff.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH | BUREAU OF ENVIRONMENTAL HEALTH

Information About Recreational Camps for Children in Massachusetts: Questions and Answers for Parents and Guardians

WHAT IS A LICENSED RECREATIONAL CAMP FOR CHILDREN?

A licensed recreational camp for children may be a day or residential (overnight) program that offers recreational activities and instruction to campers. There are certain factors, such as the number of children the camp serves, the length of time the camp is in session, and the type of entity operating a program, that determine whether a program is considered a recreational camp under Massachusetts law and regulations and therefore must be licensed (see M.G.L. c. 111, §127A and 105 CMR 430.000: Minimum Standards for Recreational Camps for Children).

WHAT DOES IT MEAN FOR A RECREATIONAL CAMP TO BE LICENSED?

If a camp meets the definition of a recreational 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 Massachusetts Department of Public Health (MDPH) and any additional local requirements.

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

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

WHAT IS THE PURPOSE OF THE REGULATIONS?

The regulations establish minimum health, safety, sanitary, and housing standards to protect the well-being of children who are in the care of recreational camps for children in Massachusetts. These regulations 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 inspection 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 facilities; 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 prevention 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 recreational camp for children, confirm the status of the camp's license, and obtain a copy of the camp's most recent inspection 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 recreational 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 orientation program before campers arrive at camp. Any counselor who supervises children in activities such as horseback riding, hiking, swimming, and other events must also have appropriate specialized training, certification, and experience in the activity. You may ask to see proof that a counselor is certified in a particular activity.

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 residential (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 Massachusetts 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 recreational camp for children must conduct a background check that includes obtaining and reviewing the applicant's previous work history and confirming three positive references. The camp must also obtain a Criminal Offender Record Information (CORI) history/juvenile report history from the Massachusetts Department of Criminal Justice Information Services to determine whether the applicant has a juvenile record or has committed a crime that would indicate the applicant is not suitable for a position 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 inspection. If an applicant resides in another state or in a foreign jurisdiction, where practicable, the camp must also obtain from the applicant's criminal information 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 Information (SORI) report from the Massachusetts Sex Offender Registry Board (SORB) for all prospective 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 protecting the public from sex offenders. The local health department will verify that SORI checks have been conducted during their annual licensing inspection. For more information concerning the Sex Offender Registry Board, and SORI information 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 written 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 times who is at least 18 years of age and is currently certified in first aid and CPR. The camp must provide backup for the health care supervisor from a Massachusetts licensed physician, physician assistant, or nurse practitioner who serves as a health care consultant. Medical specialty camps and residential 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 medication at a recreational camp. Licensed camps are required to keep all medications in their original containers and to store all prescription medications in a secure manner. If your child will be participating in off-site activities while taking prescription medication, a second original pharmacy container must be provided to the camp. The only individual authorized to give your child his/her medication 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 medications such as epinephrine auto-injectors and inhalers.) When your child's participation at a camp ends, the medication must be returned to you, if possible, or destroyed.

CAN A CAMP DISCIPLINE MY CHILD?

Yes. Camps are required to have a written disciplinary policy that explains their methods of appropriate discipline, for example, a 'time-out' from activities 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 humiliation.

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

All licensed recreational camps must have policies and procedures in place to protect campers from abuse and neglect while at camp. You may ask a camp representative for specific information on the camp's policies and procedures for reporting 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 effective for children (older than 2 months of age) when used as directed and certain precautions are observed. These products should be applied based on the amount of time the camper spends outdoors and the length of time protection is expected as specified on the product label.

Use of DEET products that combine repellent with sunscreen are not recommended, as over application 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, particularly for early morning and evening activities 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 after 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:
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 directo rto 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.

For More Information

If you would like a copy of the state regulations or additional information concerning recreational camps for children, please visit www.mass.gov/dph/dcs or call the Massachusetts Department of Public Health, Bureau for Environmental Health's Community Sanitation Program at 617-624-5757 | Fax: 617-624-5777 | TTY: 617-624-5286

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Important Webpage Links regarding Recreational Camps for Children

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
  - "Heads Up" - Concussion Awareness
  - Immunizations
  - Influenza
  - Rabies
  - Swine Flu
  - Tuberculosis
  - West Nile Virus & Eastern Equine Encephalitis
- OUTDOOR SAFETY
  - Bats
  - Beaches
  - Playground Handbook
  - DEET Insect Repellent
  - Extreme Heat Guidance
  - Security & Safety Plans
- GENERAL REFERENCES
  - American Camp Association
  - Camp Administrator Training

- 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.pdf

http://www.mass.gov/eohhs/docs/dph/com-health/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-and-head-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/vaccine-information-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/info-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/programs/id/epidemiology/providers/public-health-cdc-rabies-info-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/swine-flu.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/programs/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/programs/id/epidemiology/providers/public-health-cdc-arbovirus-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/bat-capturing.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.pdf

http://www.mass.gov/eohhs/gov/departments/dph/programs/environmental-health/exposure-topics/beaches-algae/

https://www.cdc.gov/nceh/hsb/cwh/technical_hab.htm

https://www.epa.gov/nutrient-policy-data/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/family-child-care-playground-safety.pdf
https://www.cpsc.gov/safety-education/safety-guides/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/s-u/tick-repellents.pdf
http://www.mass.gov/eohhs/docs/dph/cdc/factsheets/m-o/mosquito-repellents.pdf
https://blog.mass.gov/blog/health/safe-practices-for-mosquito-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.html

- 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-safety-security/school-safety-report.pdf

References:

- American Camp Association-New England:

http://www.acanewengland.org/

http://www.acanewengland.org/education-training/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.

http://www.mass.gov/ocabr/government/oca-agencies/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.pdf

http://www.mass.gov/eohhs/docs/dph/environmental/sanitation/105cmr480-medical-waste-off-site-log.pdf
http://www.mass.gov/eohhs/gov/departments/dph/programs/environmental-health/comm-sanitation/medical-waste.html

For More Information

If you would like a copy of the state regulations or additional information concerning recreational camps for children, please visit www.mass.gov/dph/dcs or call the Massachusetts Department of Public Health Bureau for Environmental Health's Community Sanitation Program at 617-624-5757

Revised 2018

Meningococcal Disease and Camp Attendees: Commonly Asked Questions

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 10-15% 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/info-details/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, Jamaica Plain, MA 02130

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
Phone: 617-624-5757 Fax: 617-624-5777
TTY: 617-624-5286

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

A. Prior work history for previous five (5) years including, a name, address and phone number of a contact person at each place of employment.
B. Three (3) positive reference checks from individuals not related to the staff person.

C. Obtain criminal offender record information and juvenile report (CORI/Juvenile Report) from the Massachusetts Department of Criminal Justice Information Services (DCJIS).
D. 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

A. Prior work history for previous five (5) years including, a name, address and phone number of a contact person at each place of employment.
B. Three (3) positive reference checks from individuals not related to the staff person.
C. Obtain CORI/Juvenile Report from the Massachusetts DCJIS.
D. SORI check from the Massachusetts Sex Offender Registry Board.
E. 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-out-ofstate-criminal-records.html.

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

A. Prior work history for previous five (5) years including a name, address and phone number of a contact person at each place of employment.
B. Three (3) positive reference checks from individuals not related to the staff person.
C. Obtain CORI/Juvenile Report from the Massachusetts DCJIS.
D. 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.
E. 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

Sex Offender Registry Board

978-740-6400
https://www.mass.gov/orgs/sex-offender-registry-board

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/linelist 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 collecting 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 Alcohol-based 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 Mattress covers soiled with vomitus or feces should be removed and promptly cleaned and disinfected or discarded. o Handle linens, sleeping bags, and clothing soiled with vomitus or feces as 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.

  o 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 water. 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 water. Allow surfaces to air dry. Food that was in the area when the accident occurred should be thrown away.

  o 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
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
.050	Current license to operate a Recreational 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)				# CORI Viewed_____ # SORI Viewed_____

	• Out-of-state/International criminal background checks available (as needed)				
.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:_____

Inspection Form

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 application)	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."				

Inspection Form

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

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 volunteer required when transporting: staff/ C rs to the pick-up/drop-off • 8+ campers under 5 yrs. of • 2+ campers with physical • dicaps				
.251(I)	Camper under the age of 7 are not transported 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)					
..110000((AC))(B(F))	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 counselor 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 Care Consultant Agreement**				
.159(A) **(1-5)**	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 Auto-Injectors • 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)**	**MD PA NP RN LPN** with CPR/First Aid certificate **OR** 18 yrs.+, with First Aid/CPR certificate				
.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 other camp staff designated to administer 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 administer 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 Auto-Injectors, 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	Injury and Incident Report(s) completed for a fatality, serious injury/incident, or medication administration error. Electronic 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				

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

HEALTH/MEDICAL RECORDS					
.150 .160(C)(F) (G)(H)	Health Records for Campers & Staff Staff/Campersunder 18 yrs. : • Address, Parent/Guardian and Health Care Provider contact information • Authorization for medication administration, emergency care, and selfadministration of epi-pens/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* Exemption Documentation				~~Number of Records~~ Checked: _____
.153					
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 onsite aquatics activities shall have an aquatics director (Lifeguard 21 certificate, supervisory evious experience in position)				
.020 .103(A)(B)	Lifeguard (LG) present for swimming/watercraft activities who is 16 yrs+ with a Lifeguard Certificate, CPR and First Aid Certificates				

Inspection Form

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(STATE SANITARY CODE, CHAPTER IV)

SWIMMING					
.430	MA Swimming Pool in compliance with 435 105 CMR and. 000 (Permit Posted) and compliant with VGB Act pool fence requirements				
.432	MA Bathing Beach in compliance with 105 445 CMR .000. Beach signage, weekly water suff sampling, icient water clarity, 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: • ARC Basic Water Rescue OR LG; and • ARC Small Craft Safety OR ACA 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: • Boater Safety Education Certificate issued b MA; and • In person training specific to watercraft activities being overseen				
.103(B)(4)(5)	White water paddlesport activities: • 2 counselors in separate previous watercrafts with • easxspiefireiedoree difficult than Class • ers N • ng/motor- powered activities in conditions hazardous				

	ified with ARC Level 4+ Certificate				
.103(B)(6)	Written boating safety plan including procedures fo emergencies on the water				

Inspection Form

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

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 Firing line in place, no crossing without				
.201(D) .201(E)	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				
CHALLENGE COURSE OR CLIMBING WALL					
.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 AND STRUCTURES					
.457	Day Camp provides shelter for on-going 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 Toilets located less than 200 ft from sleeping rooms,				
.370(C)(D)	all windows/openings screened, and screen doors equipped with self-closing devices				
.372	aO spuepraptloyr o sfh taolill eptr opvaipdeer ,a st oaallp t,o hilaentsd/ dharynidnwg maseht hsiondk, s 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 prohibited amp operating hours				
.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 locked area				
.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 retention after period				
	USE THE SPACE BELOW TO DESCRIBE VIOLATIONS MARKED ABOVE				

Field Trip/ Offsite Itinerary Form

Camp Site Name and Address: _____

Name of Program attending Field Trip/ Offsite Activity: _____

Group(s) Attending Field Trip/ Offsite Activity:_____

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

Program/ Staff Information

Name of Group attending Field Trip/ Offsite Activity: _____

Contact Information for Staff Supervising Trip/Activity:

Name:_____ Title: _____

Cell: _____

Email:_____

Field Trip Location: _____

Field Trip/ Offsite Itinerary 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 Information	**Name**	**Office Telephone**	**Cell Phone**	**Email**
Camp Director 1				
Camp Director 2				
Counselors				
Program Manager				
Other				

Emergency Meet Up Location on Trip:_____

Name & Contact Number for Support Staff at trip location:

_____

Field Trip / Offsite Activity Check List and Planning Form

Prior to departing on any Field Trip or Offsite Activity, please ensure the following action steps have been completed. These action steps are the recommended minimum procedures that must be performed before a group can leave the camp. Additional steps may be added.

Administrative / Planning Steps

Field Trip/ Offsite Itinerary Form

- ❑ Field Trip has been preapproved
- ❑ Itinerary 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 Information and Supplies by Staff

- Health Care Supervisor for Trip has necessary Medication for Campers, and shall be responsible for transporting to and from Trip according to HCC Recommendations

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

Each Group has updated and complete staff binder that includes:

- ○ A Roster that documents the daily attendance of Campers in the Group.
  - ■ Group(s) Roster and Attendance List provided to Site Supervisor, Camp Director or designee prior to leaving site
- ○ Copies of Camper Registration Files that include Medical Information, Parent/Guardian Emergency Contact Information and Consent/ Release Signatures
- ○Copies of Accident/ Injury Reporting Forms
- ○Copies of all Camp Itineraries and Field Trip/ Offsite Activity Forms
- ○ Lists of all Emergency Telephone Numbers for Emergency Care, as well as all related camp Staff and Administrative Office Contact Information
- ○ Copies of Staff Medical and Emergency Contact Information for that Group.
- ○ Copies of all Emergency Contingency Plans for Staff reference
- ○ Copies of any Trip Confirmations/ Reservations- with notes about check in, parking, prope 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 Environmental Health Community Sanitation Program
250 Washington Street, Boston, MA 02108-4619
Phone: 617-624-5757 Fax: 617-624-5777
TTY:617-624-5286

CHARLES BAKER
Governor

KAREN E. POLITO

Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICABHAREL, MD, MPH
Commissioner
Tel: 617-624-6000
www.mass.gov/dph

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 Massachusetts, and there will probably be some risk to people. However, children can continue to spend time outdoors for recess and other activities during the day with the use of repellent—as well as wearing long-sleeves, long pants, and socks when possible. Outdoor activities should be avoided between dusk and dawn, when mosquitoes are most active.

EEE (Eastern equine encephalitis) 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 particular 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 setting:**

- 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.3

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 instructions on the product label. If you have questions after reading the label, such as how many hours does the product work for, or if and how often 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. Putting on a larger amount does not make the product work any better. 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.

[3] https://www.epa.gov/insect-repellents/using-insect-repellents-safely-and-effectively

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

_____ _____

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 immediatelyImmediately 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 EM 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 addition to any other necessary personal protective equipment needed to protect the individual responsible for cleaning the blood spill from blood-borne pathogens.

2. Use a disposable absorbent towel to clean the area of the spill as thoroughly as possible. Place soiled towels in contaminated materials bag.
3. All surfaces that have been in contact with the blood should be wiped with a 1:10 dilution of household bleach can (this solution 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.
4. After 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 after 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 Mike — Director of Community Relations/ Media Inquiries
- DoCurral Mike — Director of Facilities (857)-325-4680
- Pojman Shelly — Assistant Headmaster (508)-934-6655
- 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-of-children-families/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 th• e 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 su•re 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:

I. The signal for an evacuation of the facility is ACTIVATION OF THE FIRE ALARM SYSTEM.

II. 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.

III. 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.

IV. Campers should remain quiet at all times.

V. 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:

I. 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,

II. Smith Art Center, and Bauer Science

Building should proceed to the Smith Theater and gather in designated areas, by group level.

III. 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.

IV. 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.

V. All campers and staff must remain in the assigned gathering places until the Camp Director or his designated representative gives further direction.

VI.

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:

I. 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.

II. When the signal sounds, all campers and staff should proceed to the nearest classroom or office.

III. The classroom or office door should then be locked. An adult should be present in each occupied room.

IV. Campers and staff should position themselves in the room in a way that prevents their being seen
V. 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.

VII. A message via the school-wide intercom system may provide further instructions.

VIII. 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. The child will be reminded of the behavior guideline and program rules, and a discussion will take place. This must be done in a positive manner and, if possible, out of the earshot (but always within 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.
4. 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.
5. Pick-up and drop-off are generally not appropriate times for this type of communication with parents.
6. If warranted, the camp director will schedule a conference with the parent so they can determine the appropriate action to take.
7. 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.
8. 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.
9. 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.
10. 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)

2. 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)

3. 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)

4. 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

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

6. 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

7. 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.

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

Camper and Medication Information

Camper's Name, Gender and Age: _____

Name and Dosage of Medication: _____

Route: _____ Frequency: _____

Year: _____

Directions: Initial with time of medication administration. Include a complete printed name, signature and initials of person administering medication below.

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
May																															
June																															
July																															
Aug																															

Initials of individual administering medication

Printed Name and Signature of individual administering medication

1.	
2.	
3.	
4.	
5.	

Codes for administration: (A) Absent (E) Early Dismissal (F) Field Trip (N) No Medication available (O) No Show (X

CAMPER RELEASE

.190 (B)Camper released only to Parents/Guardians or: Designated individual with Parent/Guardian authorization (electronic or hard copy form) Authorized alternative arrangements

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

Camper's School

Camper's Grade

Person to Notify in Case of Emergency

Phone Number of Emergency Contact

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

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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Lieutenant Governor

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ADVISORY

To: Recreational Camp and Municipal Program Operators

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

Date: June 14, 2024
Re: Extreme Heat-Related Illness and Preventative Measures for Recreational Camp and Municipal Program Operators

Many summer recreational camps for children and municipal programs offer outdoor activities 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 Prevention (CDC) issued guidance on preventing heat-related illness to protect individuals through prevention, identification, and treatment. The Massachusetts Department of Public Health's Bureau of Climate and Environmental Health (BCEH) offers recreational camp and municipal program operators this advisory to review, implement, and share preventative measures with their staff and volunteers.

The first step to mitigating risk is preparation. The CDC, in partnership with the National Oceanic and Atmospheric Administration's (NOAA) National Weather Service (NWS), has developed a HeatRisk Dashboard to provide a nationwide seven-day heat forecast model. This tool enables users to search by zip code, identify when air temperatures may reach levels that could negatively impact their health, and provides recommendations on actions 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 practices. 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. Regulation *105 CMR 430.000: Minimum Standards for Recreational Camps for Children (State Sanitary Code Chapter IV)*, sets forth minimum standards for housing, health, safety, and sanitary conditions for minors attending recreational camps for children in the Commonwealth. These requirements and

suggested best practices identified below, provide an opportunity for recreational camp and municipal program operators to safeguard their campers, staff, and volunteers from heat-related illness:

- Educate campers and parents about the importance of hydration. Send fact sheets home at the beginning of the season or before a predicted heat wave:
  - Heat Stress: Hydration (cdc.gov);
  - Estrés por calor: Hidratación (cdc.gov);
- Create accessible fun cooling water stations during outdoor events (sprinklers, misters, etc.);
- Schedule water breaks frequently throughout the day in shaded or indoor areas;
- Provide artificial shaded areas with canopies or tents, when natural shade is not available;
- Provide ice as needed;
- Reschedule outdoor activities to the coolest part of the day, like the morning and evening hours;
- Increase ventilation to sleeping and assembly areas, provide fans if possible;
- Ensure windows that get late morning and/or afternoon sun are covered or tinted;
- Encourage everyone to wear clothing to keep cooler and protect from the sun:
  - o Light-colored and loose-fitting 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**;
- Increase access to safe recreational swimming or water related activities:
  - o Provide swimming only at permitted beaches and swimming pools that comply with water quality and clarity standards and have appropriate safety measures in place such as lifeguards, trained staff, and safety equipment;
  - o Ensure there is sufficient natural or artificial shade available for those children and staff waiting in line to enter the swimming area, or for those children and staff who are not swimming;
  - o 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:
    - Ensseu oreth tehre srtea fisf teon omuognhi tdoirs ipnofeocl tdioenc kasn odn t rheigahtm heenatt / and healthy pool during operation
    - Conduct water testing more frequently than the minimum 4 times a day to maintain the disinfection level during and after 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 medication use);
  Implement a buddy system for observing fellow staff/volunteers for early signs and symptoms of heat-
- related illness;
- Identify priority locations in cooler areas to be made available for heat sensitive, at-risk, or new campers and staff/volunteers who may not be acclimated to extreme heat conditions; and
  Camps that provide sport related activities should take additional precautions to schedule activities and rest breaks to protect their young athletes. Refer to the Massachusetts Interscholastic Athletic Association (MIAA) Heat Modification 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. Additional information is available at: https://www.cdc.gov/disasters/extremeheat/warning.html

Signs of Heat Cramps	You Should	Go to the Hospital if:

• Heavy sweating • Muscle pain or spasms (often in the abdomen, arms, or calves)	• ***Give them water, clear juice, or a sports drink*** Tell them to stop • exerting themselves and/or stop physical activity and move to a cool place Have them wait for • cramps to go away before doing any more physical activity	• 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 Exhaustion	**You Should:**	**Go to the Hospital if:**
• Lots of sweating Fast/weak • pulse Nausea/vomiting • Headache/dizziness Fainting • (passing out) Muscle cramps • Cold, pale, and clammy skin • Fatigue/tiredness/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 getting 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 • Throbbing headache • Nausea • Losing consciousness (passing out) • Altered mental state Unconsciousness	• **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 them with cool hose water • Move them to a cool place • Wait until 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 vomiting, turn the person on their side to keep the airway open	

The Department of Public Health's Community Sanitation Program recommends this information be shared with all recreational camp or program staff and volunteers, including the on-site Health Care Supervisor(s). As always, thank you for your cooperation and assistance with this important public health matter.