BROOKLINE TENNIS ACADEMY SUMMER SPORTS CAMPS

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Background Check, References & Verification and Volunteer policies

105 CMR: 430.090 BACKGROUND CHECKS

Brookline Tennis Academy Camp is to obtain background checks on all prospective employees and volunteers. Each candidate is selected for a phone or skype interview, followed by an in-person interview. Three reference checks are completed and then an offer of employment is made. Returning staff prior references may be used, however if there is a gap in employment for one or more camp seasons, new references willbe required. Each employee has to complete the hiring paperwork of which the following are kept on site at The Roxbury Latin School:

- Certificate of Immunization
- Health History
- Certification (lifeguard, CPR, First Aid, etc.)
- Criminal Offenders records Investigation (CORI) including Juvenile Reporting
- Sexual Offenders Records Investigation (SORI)
- Out of state/international criminal background checks
- A work history/resume including the past 5 years
- Three Positive Reference Checks
- Employment Eligibility Form
- Juvenile Records

File Maintenance

Employee files are retained for three years upon leaving and applications of those not selected are kept on file for future use for up to one year.

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

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Policy Statement Regarding Background Information Checks for Staff and Volunteers at Recreational Camps for Children

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

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

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

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

1. MA Resident

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. Obtain CORI/Juvenile Report
C. from the Massachusetts DCJIS. SORI check from the Massachusetts Sex Offender Registry Board. Obtain a
D. criminal record check, or equivalent where practicable*, from the staff person's state of residence. Information
E. 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 theUnited 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.

W here 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

STAFF ORIENTATION AND TRAINING

105 CMR: 430.091

All camp staff will receive two days of training prior to the opening of camp. The training will include an overview of the camp its philosophy, organization, policies, and procedures. The staff will receive additional in-service training in the safe and appropriate use of all the equipment associated with the various camp activities.

● All Counselors, junior counselors, and other staff will complete the *"Heads Up"* on-line head injury safety training. All camp staff will review the emergency action plan. (**All BTA staff undergo annual training,which includesStaffTraining,CDC'sHead'sUpConcussiontrainingand First Aid Procedures.)**

- All camp staff will be trained in prevention of disease transmission to the standards of the American Red Cross or its equivalent.
- The plans for Fire Evacuation, Disaster, Lost Camper, Lost Swimmer, Traffic Control, and Special Contingency Planning will be reviewed.
- Staff will review their individual job descriptions and will understand the expectations for their specific job.
- In addition, staff will be taught to recognize signs of abuse and/or neglect and the proper reporting procedures.

Appendix B: Staff Orientation Schedule

PREVENTION OF ABUSE AND NEGLECT

105 CMR: 430.093

SuspectedChildAbuse/Neglect Not Involving Staff:

The safety and security of campers is of utmost importance. When a suspected case of child abuse/neglect involving campers and not involving Brookline Tennis Academy staff is brought to the attention of the Camp Director, the following procedure will be followed:

1. By the end of the working day in which the report was made, the Camp Director will meet with the staff person who made the report of suspected abuse/neglect, and consult with a Department of Children & Families Worker.
2. If necessary and appropriate, the Director or his/her designate will contact the parents of the alleged victim for additional information.
3. In cases where abuse/neglect is strongly suspected, the Camp Director or his designate will file a written 51-A with the Massachusetts Department of Children and Families and Inspectional Services Department (City of Boston).
4. The headmaster or his assistant will be notified that a 51-A was filed.
5. Massachusetts Department of Public Health will be notified that report has been filed with DCF.

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 DCFhas developed educational materials to provide information regarding the Warning Signs of Child Abuse and Neglect

Abuse/Neglect of Camper by a Camp Staff Person

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 or federal law will be reported to, and investigated by the proper authorities

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PHILOSOPHY

At BTA, a positive approach to behavior management begins by offering an engaging, developmentally appropriate camp experience. By 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 staff are expected to:

- Create a constructive,positive atmosphere for children where strengths are maximized and weaknesses are minimized.
- 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.
- Campers will be responded to with respect, consideration, and treated equally regardless of sex, race, religion, culture, disability, sexual orientation, gender identity or economic status

● Constructive methods must be used for handling inappropriate dited 5/25/21 individual and group behavior and any corrective action must not be associated with food, rest or other physical requirements. Corporal punishments of any kind, including isolation, berating, humiliating, threatening, frightening or physical punishments are strictly prohibited.

● Staff will avoid being alone with a camper in a closed-in space or non-public area here other staff or volunteers cannot observe them.

Staff must report any incident that may be in violation of the above policy to the Camp Director within 24 hours of the occurrence. An investigation will be conducted promptly. Staff involved may be suspended or put on administrative leave pending the results of the investigation. If BTA Summer Sports Camps conclude there has been a violation of the policy, disciplinary action, up to and including termination of employment will occur. If an allegation is made against a staff member, no contact will occur between that staff member and the child involved until the investigation by DCF is completed. The safety and security of campers is of utmost importance. When a suspicion of possible

child
abuse/neglect involving camp staff is brought to the attention of any staff member, that staff member must immediately notify the Camp Director. The Camp Director will take various steps to investigate, notify the appropriate internal and external authorities and document the situation.

If it is determined that abuse or neglect may have occurred, the Department of Children and Families will be contacted and a written 51-A will be filed. The Massachusetts Department of Public Health and Inspectional Services Department (City of Boston) will be notified that a report has been filed with DCF.

Appendix C: 51 A form
Appendix D: Child Abuse and Neglect- Mandated Reporter Guide

GENERAL SUPERVISION

CMR430.100-CMR430.102

Camp staff receive training at a two-day orientation and in-service training prior to the first day of sports specific clinics. Staff will have at least 4 weeks experience as a participant in structured group camping and/or at least four weeks experience in a supervisory role with children.

Camp Director must be at least 21 years old. He/She must have 2 years administrative experience at a recreational camp and/or have successfully completed a course in camp administration. Background information on the Camp Director is kept on file at the BTA Summer Sports Camps (refer to section CMR 430.090).

When director is off site an appropriate designee will be responsible for administration of the camp. The staff will be notified who is in charge at all times.

The ratio of staff to camper is 1:10 for campers ages 7 and older, and a 1:5 ratio for campers ages six or below. To successfully maintain these ratios, counselors must be within the line of sight and close proximity to their campers. Jr. Counselors may be included in the ration at 50% (2 Jr. staff=1 staff) but must always be in the presence of a counselor. Camp staff are supervising children at all times with appropriate staff camper ratios. All Jr. Counselors shall be at least 16 years of age. They will have completed staff training. All Jr. Counselors will be at least 3 years older than the campers they supervise.

Appendix F: Camp Director Training Certifications or resume

Brookline Tennis Academy Summer Camps

HEALTH CARE POLICY FOR BTA Summer Sports Camp

105 CMR 430.159(B) 430.150-430.161

Thesepoliciescanbefoundattheendofthisbinder: starting after page 22.

PERSONAL HYGIENE

105 CMR: 430.162

Campers are expected to practice good personal hygiene, including washing hands regularly, especially after using restroom facilities. Campers are expected to bring active clothing and appropriate shoes for camp. Campers will be encouraged to bring a change of clothing in case one gets soiled or damaged. Campers will be encouraged to demonstrate proper hygiene at all times.

HEALTH RECORDS*105 CMR: 430.150- 430.153 AND 430.156*

The health records for each campers, staff members and volunteers will be maintained by the Health care supervisor. All health records will be made readily available upon request to the Massachusetts

Department of Public Health and the local board of health for licensing purposes. Records will be kept on site by Shelly Mars (Director of Brookline Tennis Academy) for three years.

Health records for all campers and staff under 18 years of age will include:

1) The camper's or staff member's name and home address and contact information.

2) The name, address and telephone number of the camper's or staff member's parent or guardian.

3) A written authorization for emergency medical care signed by a parent or guardian.

4) The camper or staff member's health care provider and health maintenance organization: name, address and telephone number

5) If the camper or staff member brings a prescribed medication from home the required documents include:

    a. A parental authorization form must be signed by the parent or guardian.

    b. A signed written medication order form is to be completed by the child's licensed prescriber.

6) Copies of injury reports, if any, required by 105 CMR 430.154.

7) Required health documents:

    a. A current certificate of immunization indicating compliance with 105 CMR 430.152.

    b. A current medical health history including allergies, required medications and any health condition or impairment that may affect the individual's activities while attending came.

    c. A report of physical examination dated within the last 18 months.

Health records for staff greater than 18 years of age shall include:

1) The staff member's name and home address.

2) The name, address and phone number of an individual, if any, to be contacted in the case of emergency.

3) The name, address and phone numbers of the staff member's health care provider or health maintenance organization, if any.

4) Copies of injury reports, if any, required by 105 CMR 430.154.

5) A current medical health history including allergies, required medications and any health condition or impairment that may affect the individual's activities while attending came.

6) A report of a physical examination conducted during the preceding 18 months.

7) A certificate of immunization indicating compliance with 105 CMR 430.152.

REQUIRED IMMUNIZATIONS

105 CMRP: 430.152

Hepatitis B: 3 doses required for kindergarten-12th grade, and college. laboratory evidence of immunity is acceptable.

DTaP/DTP/DT/Td/Tdap: 5 doses of DTaP/DTP required for school entry unless the 4th dose is given on or after the 4th birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP/DTP. One dose of Tdap is required for all students entering grade 7-12, full-time college freshmen-graduates and all health science students. If it has been <5 years since the last dose of DTaP/DTP/DT/Td, Tdap is not required but is recommended regardless of the interval since the last tetanus-containing vaccine. Polio: 4 doses required for school entry, unless the 3rd dose is given on or after the 4th birthday, and ≥6 months following the previous dose, in which case only 3 doses are needed. Administer the final dose in the series on or after the 4th birthday and ≥6 months following the previous dose. If 4 doses are administered before age 4 years, a 5th dose is recommended at age 4-6 years.

MMR: 2 doses are required for kindergarten-grade 5, grades 7-12. laboratory evidence of immunity is acceptable.

Varicella: 2 doses required for kindergarten-grade 5, grades 7-12, full-time undergraduate and graduate students and all health science students, unless they have a reliable history of chickenpox. A reliable history includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee; or 2) laboratory evidence of immunity.

For Staff 18 Years of Age or Older:

1. Measles, Mumps, Rubella Vaccine: 2 doses of live measles-containing vaccine administered at/or after 12 months of age (at least four weeks apart) are required (1 dose if born before 1957 outside of U.S.). Laboratory evidence of immunity is acceptable.

2. Varicella: 2 doses required if born in OR after 1980; OR if not born in U.S.

3. Diphtheria and Tetanus Toxoids: At least 3 doses of DTaP/DTP/DT/Td are required. A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years since the last dose of DTaP/DTP/DT/Td vaccine.

Immunization or Physical Exam Exceptions:

(A) Religious Exceptions. If a camper or staff member has religious objections to physical examinations or immunizations, the camper or staff member shall submit a written statement, signed by a parent or legal guardian of the camper or staff member if a minor, stating that the individual is in good health and the general reason for such objections.

(B) Immunization Contraindicated. Any immunization specified in 105 CMR 430.152 shall not be required if the health history required by 105 CMR 430.151 includes a certification by a physician certifying that he or she has examined the individual and that in the physician's opinion the physical condition of the individual is such that his or her health would be endangered by such immunization.

(C) Exclusion. In situations when one or more cases of a vaccine-preventable or any other communicable disease are present in a camp, all susceptible children, including those with medical or religious exemptions, are subject to exclusion as described in the *Reportable Diseases and Isolation and Quarantine Requirements* (105 CMR 300.000).

(D) For additional information regarding immunization schedule visit -

InterimClinicalConsiderationsfor Useof COVID-19Vaccines | CDC

EUA Advice-Information Request (fda.gov)

The Commonwealth of Massachusetts
ExecutiveOffice ofHealth and HumanServices
Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
305 South Street, Jamaica Plain, MA 02130

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Lieutenant Governor

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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, conjugate (MenACWY)	**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, conjugate (MenACWY)	**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

§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)
COVID-19 vaccine	1vCOV-mRNA	COVID-19 Vaccine, mRNA (Pfizer-BioNTech)
		Spikevax/Moderna COVID-19 Vaccine
		Novavax COVID-19 Vaccine
	1vCOV-aPS	Dengvaxia
Dengue vaccine	DEN4CYD	Daptacel
Haemophilus influenzae type b vaccine (PRP-T conjugate)	HepA	Infanrix
Hepatitis A vaccine	HepB	Havrix
Hepatitis B vaccine	HPV	Vaqta
Human papillomavirus vaccine	IIV3	Engerix-B
Influenza vaccine (inactivated: egg-based)	ccIIV3	Recombivax HB
Influenza vaccine (inactivated: cell-culture)	LAIV3	Gardasil 9
Influenza vaccine (live, attenuated)	MMRMenACWY-CRM	Fluarix
Measles, mumps, and rubella vaccine	MenACWY-TT	FluLaval
Meningococcal serogroups A, C, W, Y vaccine	MenB-4C	Flublok
Meningococcal serogroup B vaccine	MenB-FHbp	FluMist
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	M-M-R II
Mpox vaccine	Mpox	Menactra
Pneumococcal conjugate vaccine	PCV15	Menveo MenQuadfi
	PCV20	Bexsero
Pneumococcal polysaccharide vaccine	PPSV23	Trumenba
Respiratory syncytial virus vaccine	RSV	Jynneos
Rotavirus vaccine	RV1	Vaxneuvance
	RV5	Prevnar 20
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Pneumovax 23
Tetanus and diphtheria vaccine	Td	Abrysvo
Varicella vaccine	VAR	Rotarix
		RotaTeq
		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, inactivated poliovirus, and hepatitis B vaccine	DTaP-IPV-HepB	Kinrix
Measles, mumps, rubella, and varicella vaccine	MMRV	Quadracel
		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. Theuseof 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 **(Addendum)**
6. Review new or updated ACIP guidance **(Appendix)**

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

- CompleteAdvisoryCommittee 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/

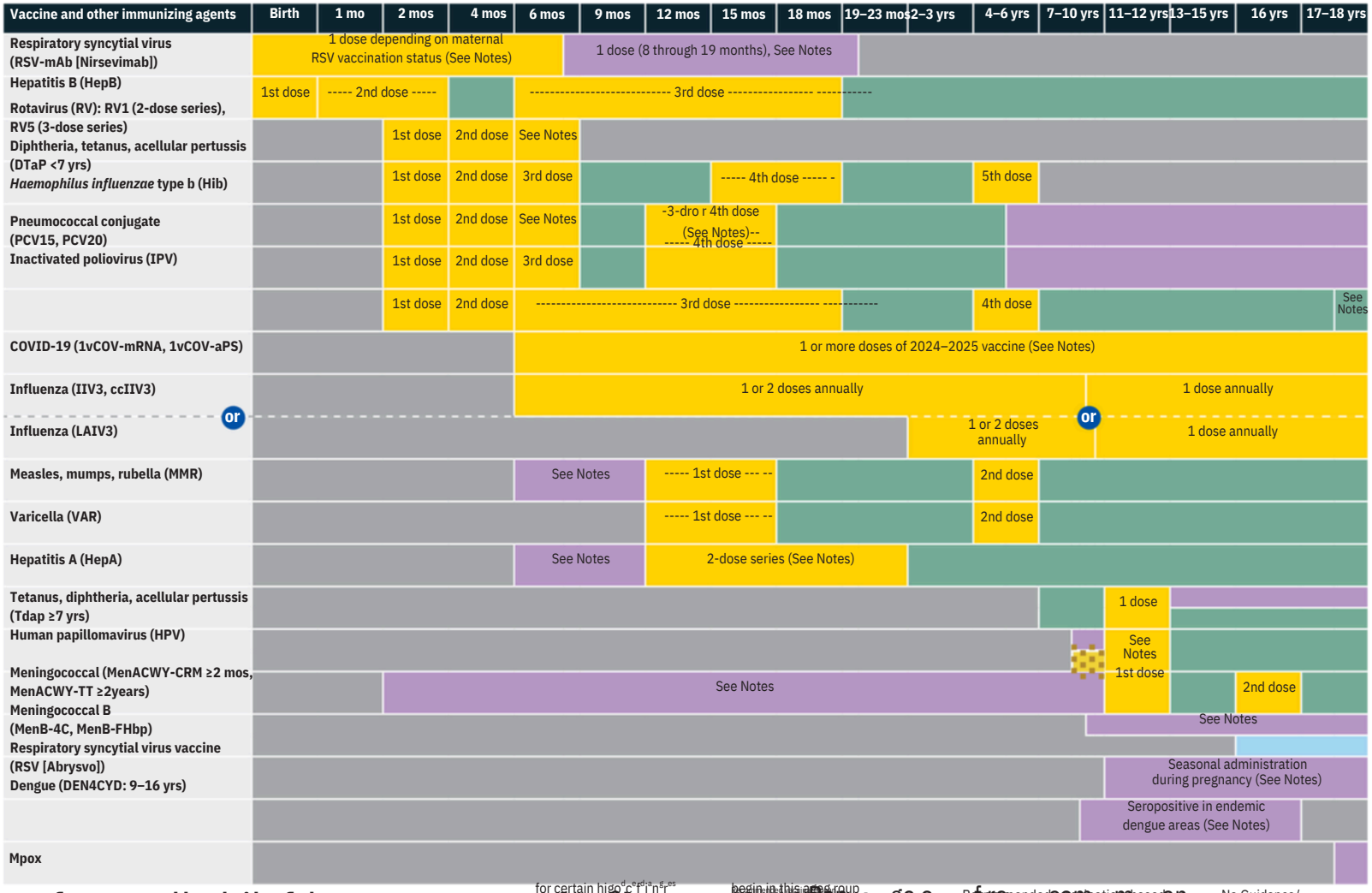
Scan QR code for access to online schedule

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).



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for certain high-risk conditions or populations

begin in this age group

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 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	2 years	MenACWY-CRM MenACWY-TT **6 months**			
Meningococcal ACWY		**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**	**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**			
Hepatitis A	N/A				
Hepatitis B	N/A		**8 weeks *and* at least 16 weeks after first dose** **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.		
Inactivated poliovirus	N/A			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 preceding12 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 Vacc

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.

Specialsituation

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-19vaccination - continued

y **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**

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

Age 5–11 years

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

y **Unvaccinated:**

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

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

- **Previous vaccination with Moderna**

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

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

- **Previous vaccination with Pfizer-BioNTech**

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

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

y **Completed initial 3-dose vaccination series before 2024–25 vaccine with:**

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

Age 12–18 years

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

y **Unvaccinated:**

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

y **Incomplete initial vaccination series before 2024–25 vaccine:**

- **Previous vaccination with Moderna**

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

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

- **Previous vaccination with Pfizer-BioNTech**

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

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

- **Previous vaccination with Novavax**

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

Notes

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

COVID-19vaccination - continued

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

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

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

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

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

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

Dengue vaccination (minimum age: 9 years)

Routine vaccination

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

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

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

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

Routine vaccination

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

Catch-up vaccination

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

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

Special situations

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

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

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

Routine vaccination

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

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

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

Catch-up vaccination

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

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

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

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

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

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

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

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

Notes

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

HepatitisBvaccination - 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 andcatch-upvaccination

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 pimromteucntoesdupppressed s who require a environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

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

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Notes

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

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

Routine vaccination

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

y MMR or MMRV* may be administered

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

Catch-up vaccination

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

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

Special situations

y **International travel**

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

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

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

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

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

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

Routine vaccination

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

Catch-up vaccination

y (**A**m**g**i**e**n i**1**m**3**u**–**m**15** i n**y**te**a**r**v**r**s**a:l: 1 8 d woesek nso)w 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-yearcollege students who live in residential housing (ifnotpreviously vaccinated at age 16 years or older) or military recruits: 1 dose Menveo* or MenQuadfi

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

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

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

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

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

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

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

Notes

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

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

Shared clinical decision-making

y **Adolescents not at increased risk age 16–23 years (preferred age 16–18 years)* based on shared clinical decision-making.**
- **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 f isodr -Mjoebn -Ba,i dse-sec wdmww-m.cednci.nggo-vb/ v-ashccairneeds-/ chlcinpi/caadl-m dine/cdisoiwonn-lmoaadks i/ng.pdf- Person

Special situations

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

- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

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

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

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

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

Special situations

y 2**A**-**g**de**o** **1**se**8** s**y**ee**r**a**i**er**ss**, **a** 2**n**8**d** d **a**a**t**y **r**s**i** s**a**k**p** a**f**o**r**t**r**. **mpox infection**: complete

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
  SSeexx aint aas csoomcimateiornci awli tshe xa vlaernguee publicevtheinr ingeographic area where mpox transmission is occurring
- Persons who are sexual partners of the persons described above
- Persons who anticipate sexual exposures (including commercial sex work) in a setting described above

y **Porre Jgynnannecoys:** uTshee rine pisr ecgunrraennctyly d nuoe AtoC IlaPs rke ocof msamfeetny ddaattiao nin pregnant women. Pregnant women with any risk factor described above may receive Jynneos.

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

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

Routine vaccination with PCV

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

Catch-up vaccination with PCV

y PHCeVa lstheyri echs:i l1d rdeons aeg PeCs V2–4 years with any ir

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

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

Special situations

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

Age 2–5 years

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

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

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Pneumococcal vaccination - continued

Age 6–18 years

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

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

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

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

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

Age 2–5 years

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

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

Age 6–18 years

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

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

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

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

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

pFoatri eganeitdes wtahmedoi,n pinlega wseh ircehfe prn teou tmheo cmoocbcaille v aapcpc,i nwehsi cah 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– Marchinmost ofthecontinental 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 **pArgeems a8t–u1r9it ym roenqtuhisr iwngit mh cehdricoanli cs gluspaign fdiinsgeaasnebeof 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 during 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 notstartthe series on or after age 15 weeks, 0 days.

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

yFor other catch-up guidance, see Table 2.

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Notes

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 e7ya –(Dc3aoh 6d sporeegsn 2aen mcyi,n paraeyfde rvabbelye ri nta ednmtliyn aisdtemriendis ates reeadr layf taesr 3a tm leoanstth 4s av be counted as valid).

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*

**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
3. Practice Guidelines for Immunization.
4. See package inserts and FDA EUA fact sheets for a full list of vaccine ingredients. mRNA COVID-19 vaccines contain polyethylene glycol (PEG).
   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

Vaccinesand 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 ianfateti 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	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	•• SP•Sere[illegible]	[illegible]
Measles, mumps, rubella, and varicella (MMRV)	• Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent • For MMRV only: HIV infection of any severity	Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • [illegible] •ForMenACWY-CRMonly:Pretermbirthifyoungerthanage9months
MeningococcalACWY(MenACWY) MenACWY-CRM[Menveo] MenACWY-TT [MenQuadfi]	•Severeallergicreaction(e.g.,anaphylaxis)afterapreviousdoseortoavaccinecomponent3 • For Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid— or CRM197—containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever • Pregnancy
Meningococcal B (MenB) MenB-4C [Bexsero] MenB-FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever • Moderate or severe acute illness, with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3 • Severe allergic reaction to a tetanus toxoid-containing vaccine • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Moderate or severe acute illness, with or without fever
Mpox (Jynneos)	• SSeevveerree aatlllleerrggiicc rreeaaccttiioonn ((ee..gg..,, aannaapphhyyllaaxxiiss)) atoft aenr ya dpirpehvtihoeursi ad-ot-sec[illegible]	• Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV) Pneumococcal polysaccharide (PPSV23)	component3 • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine	• Moderate or severe acute illness with or without fever • Pregnancy
Poliovirus vaccine, inactivated (IPV)	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
RSV monoclonal antibody (RSV-mAb)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component5	• Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component3	• Altered immunocompetence other than SCID
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	• Chronic gastrointestinal disease • 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 • Faonro Tthdearpi ai ndbocelnenelpy tcih:fa Eaulsoep awtihthy i(ne 7.g .d, acyosm oaf ,a ddemcrineiassteradt iloenv eolf o pfr ceovniosucsio duossnee sosf ,D pTrPol,o DnTgaePd, soeri zTudraeps) not attributable to vaccine	• Htеoisra ttontetur-atyfsnost Ao-uxoroothtaxednuii nstndh–aci-y–noptiygceonn vprgas cevcnascinictiinevie • 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) (MeMasRlVe)s, mumps, rubella, and varicella	• 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	•(, uavRso oe iepict odfe specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccina f 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. WImhemnu an ipzraetcioanu.t iwown wis. pcdrecs.geonvt,/ vvaaccccciinneasti/ohnc ps/haocuipld- rgeecnse/graelnlye rbael-dreecfesr/rceodn tbruatin mdiigchatti obnes i.nhdtimcal.ted if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kr
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.

INJURY REPORTS

105 CMR: 430.154

Injury prevention – all staff will assess areas, equipment, and supplies daily for cleanliness and potential hazards which will be reported to the Camp Director. Staff will be notified and children relocated if necessary. The Camp Director will study all accident reports to eliminate any hazards. Staff will enforce safety rules and teach campers personal safety, and proper use of equipment.

In the event of a serious injury, in-patient hospitalization, death of a camper, staff person, or volunteer the Camp Director will contact the Department of Public Health and Inspectional Services Department (City of Boston) a report shall be completed on a form available from the Massachusetts Department of Public Health for each qualifying incident: https://www.mass.gov/lists/recreational-camps-for-childrencommunity-sanitation

105 CMR: 430.154 Maintenance of Records

430.145 Maintenance of Records • Operators are responsible for the destruction of all records in a manner that protects the privacy of campers, staff, and volunteers. Criminal history checks shall be maintained in accordance with 803 CMR 2.15 Destruction of CORI and CORI Acknowledgement Forms

Appendix G: Camp Injury Report Form

The Health Care Supervisor will complete the DPH Recreational Camp Injury Report within 24 hours of th injury/accident and fax, mail or deliver the completed injury report to the Massachusetts Department of Public Health no later than 7 calendar days after the occurrence of the inj Camp Director should keep a copy on site and forward a copy to the Headmaster of the School.

Serious injury will include but is not limited to a situation in which suturing or resuscitation is required, bones are broken, or the child is admitted to the hospital. The injury reports will include details of the situation, any pertinent medical history and the outcome of the situation. The Camp Director will obtain names and addresses of witnesses

when appropriate and all pertinent data including
instructions given and precautions taken to avoid such happenings. The Camp Administration and staff will cooperate with law enforcement officers if applicable.

The Health Care Supervisor will:

1. Record the incident in the Medical Log Book.

2. Give one copy of the DPH Recreational Camp Injury Report to the Camp Director

3. Send one copy of the DPH Recreational Camp Injury Report to the Massachusetts Department of Public Health and Inspectional Services Department, City of Boston (completed within 24 hours and sent within 7 days of the injury).

4. Complete and send one copy of the BTA SUMMER SPORTS CAMPS injury report to the Camp Director.

Plan for notifying Parents or Guardians:

Parents/guardians will be notified via telephone by the Camp Director or Health care supervisor as soon as possible after the situation is under control.

In the event that there is an incident resulting in serious injury or death of a camper or staff member, the Crisis Management Team (CMT), including the Camp Director, Director of Studies, Headmaster, Director of Community Relations, Director of Facilities, and Assistant Headmaster will meet to devise a plan on how to inform and process the incident with the other campers and staff.

MEDICAL LOG

105 CMR: 430.155

The Health care supervisor shall maintain a medical log which shall containarecordofallcamperandstaff health complaints and treatment. The medical log shall list the date & time, name of patient, complaint, and treatment for each incident. The medical log shall be maintained in a readily available format. If kept in writing it should be in a readily available format and shall be signed by an authorized staff person. No lines shall be skipped and all entries shall be in ink. The log book should be signed by an authorized staff person. The Health care supervisor will share information from the Medical Log Book with camp staff on a "need to know" basis.

AVAILABILITY OF HEALTH RECORDS AND LOGS

105 CMR: 430.156

All medical records and logs shall be readily available to the Health care supervisor, Camp Nurse, Health Care Consultant or other health personnel. All medical records and logs shall be made available upon request to authorized representatives of the Massachusetts Department of Public Health and of the local board of health, which licenses the camp. The Department of Public Health and the local board of health shall maintain the confidentiality of information relating to individual campers and staff.

COMMUNICABLE DISEASE REPORTING

105 CMR: 430.157

In the event that an outbreak of a communicable disease occurs at the camp, it shall be the responsibility of the Camp Director, HealthCareSupervisor,ortheCampNursetoimmediatelyreporteachcaseofanoutbreak toboth the Massachusetts and Boston Department of Public Health. The report shall include the name and home address and the contact information for the parent/guardian of any individual in the camp known or suspected of having such disease. Until action on such case has been taken by the Camp Health Care Consultant, strict isolation shall be maintained.

The Health Care Supervisor or Camp Director, in consultation with the camp's Health Care Consultant, will be responsible for ensuring each suspected case of food poisoning or any unusual prevalence of any illness in which fever, rash, diarrhea, sore throat, vomiting, or jaundice is a prominent symptom is reported immediately to the Board of Health

and the Department, by email or telephone. This report shall be made by the health care consultant, health care supervisor, or Camp Director.

Information regarding meningococcal disease and immunization shall be provided annually to the parent or legal guardian of each camper in accordance with M.G.L. c. 111, § 219.
The camp will make every effort to reduce risk of infection and the transmission of communicable diseases.

Disease Outbreak Response Plan

Identification

- Screen new camper/staff as they arrive at camp for any current or resent illness. Any symptomatic campers or staff members should be referred for medical evaluation.
- Check the medical log entries daily for common ailments and/or increased frequency of cases of illness with similar symptoms (i.e., headache, vomiting, diarrhea, fever, eye infection, sore throat, etc.).
  If multiple campers and/or staff are ill, contact your local health department immediately (remember, reporting is required within 24 hours). Your children's camp may be experiencing a food, water, or person to-person transmitted outbreak.

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

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

Prevention and Contr ol

- 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.
  - 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*).
    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.
    Don't allow use of common or unclean eating utensils, drinking cups, etc..
  - o
  - o Require cleaning staff/dishwashers to observe sanitary precautions.

Restrictions andExclusions

- 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 andNotification

- 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

- The Health Care Supervisor(s) will maintain proper hand washing techniques that include washing their hands with soap and water or disinfect with hand sanitizer before and after handling any campers and before and after donning gloves. Adequate hand-washing stations will be available throughout the camp and campers/staff will be required to wash hands prior to food consumption or handling.
- Staff/Campers will be instructed to properly cover their nose/mouth when coughing or sneezing.
- Personal supplies (hats, brushes, hair ties, contact solutions) towels and drinking containers are never shared with others.
  Campers/Staff will perform hand hygiene (hand washing with non-antimicrobial soap and water, alcohol-based hand rub or antiseptic hand wash) after having contact with respiratory secretions and contaminated objects/materials.
  Staff suspected of having a communicable disease will not be permitted to work until cleared, in writing, to return by a health care professional.
- Thenurse’s officewillbedisinfected onadaily basis.All equipmentusedwith
- campers or staff will be disinfected or disposed of after each use.

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):PolicyonAdministrationofMedication:

- Training of unlicensed HCS by HCC must include content standards and tests of competency approved by the department for diabetes medications, oral and topical medications (forms can be found on our website as well as State website) Your
- policy and procedures shall include a section on the administration of medications at the camp. Your policy shall list your health care consultant(s) or health care supervisor(s) who are authorized to give medications, epi-pens and medications for diabetes per the Health Care Consultant. Policy on Epi-pens and medications for
- Diabetes Care:
  - o A camper may self-administer and possess an epi-pen IF the HCC and parent/guardian has given written approval

- A camper may receive an epi pen injection by HCC, HCS, or any other camp staff IF the HCC and parent/guardian has given written approval and the HCS or other camp staff has received training from the HCC. o Blood sugar monitoring and medication administration for Diabetes can be done by the camper if the HCC and parent/guardian has given written approval and it takes place in the presence of a HCS. o Diabetes care can be done by a HCS if the HCC and parent/guardian have given written informed consent. o 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 aquatic's director or camp director.

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

- 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.

risk

HEALTH CARE POLICY FOR SUMMER CAMP

105 CRM: 430.159 Health Care Consultant

(must be a MA licensed physician,certifiednursepractitionerorphysician'sassistanthavingdocumentedpediatric training)

Name of Health Care Consultant: Nina Diggs, RN, Healthcare Consultant
Address: 134 South Ave, Weston, MA 02493, United States

Email:Nina.diggs@gmail.com			
Health Care Policy Approved by Health Care Consultant and signed for 2024		Policies Provided to Parents (including care of ill campers, medication administration and emergency care: In Parent Handbook	

Appendix H: Health Care Consultant Agreement

105 CRM: 430.159 Health Care Supervisor(s)

(must be at least 18 years of age and present at the camp at ALL times as well as trained in First Aid and CPR (American Heart Association, Red Cross or equivalent). Each full-time staff member is provided with a copy of the camp medical policy and trained in the program's infection control procedures and implementation of policy during orientation.

Emergency Telephone Num bers

Fire: 911

Police: 911

Rescue/Ambulance: 911

Poison Control Center: 1-800-222-1222

Hospital(s) utilized for emergency

Name: Brigham & Women's Faulkner Hospital
Address: 1153 Centre Street, Jamaica Plain, MA 02130
Phone: 617-983-7000

First Aid Kit Information

Location for First Aid Kit(s):	Nurse's Office and all program areas

Location for First Aid Manual:	In each first aid kit
First Aid is administered by:	Health Care Supervisor (Registered Nurse)
First Aid Kit is maintained by:	The Roxbury Latin School Athletic Trainer, Misty Beardsley
Designated area for infirmary:	Nurse's Office located in Main Building

Emergency Procedures if parents cannot be contacted

1 Notify emergency contacts provided by parent/guardian that are on file

. Use the emergency release from with parent's/guardian's signature for EMS

2 Continue to attempt to reach a parent/guardian

.

Example3s of Situations that would require Emergency Attention

Staff trained in CPR. and First Aid are designated to administer emergency medical attention. Emergency Medical Response will be activated in the event of a life-threatening emergency.

The following list of symptoms have been identified by American College of Emergency Physicians as situations that would necessitate prompt attention and emergency medical transport.

1. Difficulty breathing (including but not limited to severe Asthma attacks not responsive to prescribed medication
2. Allergic reactions (including severe swelling, generalized rash or difficulty breathing)
3. Chest pain and pressure in chest
4. Uncontrolled bleeding
5. Severe abdominal pain
6. Possible fracture of dislocation indicated by pain and inability to bear weight or movement
7. Permanent teeth that are knocked out. Replacement must occur within 2 hours
8. Fainting or loss of consciousness
9. Convulsions or seizures
10. Severe burns, smoke inhalation or near drowning

11. Foreign bodies in nose and/or ear

12. Change in mental status (confusion or difficulty arousing)

13. Head or spine injury

WHEN IN DOUBT CALL 911 FOR EMERGENCY MEDICAL RESPONSE

Procedures for Head Injury or Concussion

BTA SUMMER SPORTS CAMPS requires that all existing and newly hired applicable staff complete the CDC's Head's Up Concussion training annually. If a member has sustained an injury to the head or if there is suspicion of a concussion, the following steps must be followed per BTA SUMMER SPORTS CAMPS protocol:

Removethememberfromphysicalactivityand/orsports-relatedplay.Observethemember for sign symptoms of a concussion if they have experienced a bump or blow to the head or body.
When in doubt, keep the member out of any form of physical activity or sports-related play.
A Concussion Signs and Symptoms Checklist provided by the CDC will be followed and completed for any m~~ember that has sustained an injury to the he~~ad or if there is a suspicion of a concussion.

Concussion Signs Observed	Concussion Symptoms Reported

1. Can't recall events *prior to* or *after* a hit or fall. 2. Appears dazed or stunned. 3. Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent. Moves clumsily. Answers questions slowly. Loses consciousness *(even briefly)*. Shows mood, behavior, or personality changes.	Headache or "pressure" in head. Nausea or vomiting. Balance problems or dizziness, or double or blurry vision. Bothered by light or noise. 5. Feeling sluggish, hazy, foggy, or groggy. Cconcfuesnitornat, ion or or memory problems. Just not "feeling right," or "feeling down".

Monitor for a minimum of 30 minutes- Intrva l assessment take place at the time of the injury and in sequential 15- and 30-minute increments.

Seek medical help immediately if...

Most concussions do not result in emergency care. However, if symptoms worsen, you notice behavioral Ach.anges or any of the following listed below, call 911 immediately. Headaches that worsen

- Seizures
- Neck Pain
- Dizziness
- Vomiting
- Increased confusion or irritability
- Weakness, numbness in arms and legs
- Unable to recognize people/places,
- Drowsy, not easily awakened or less responsive than usual

B. Inform the member's parents or guardians about the injury, and possible signs and symptoms concussion that have been observed. Give the parents or guardians the CDC's Heads Up Parent Fact Sheet on concussion.

C. Ensurethatthememberisevaluatedbyahealthcareprofessionalexperiencedinevaluating f concussion. Any member suspected of having a concussion should be evaluated by an appropriate health-care professional within a day of the "injury". Staff will not try to judge the severity of the injury. Health care professionals have a number of methods that they can use to assess the severity of concussions. Recording the following information can help health care professionals in assessing a member after the injury:

- Cause of the injury and force of the hit or blow to the head or body
- Any loss of consciousness (passed out/knocked out) and if so, for how long
- Any memory loss immediately following the injury
- Any seizures immediately following the injury
- Number of previous concussions (*if any*)

D. Keepthememberfromparticipatinginphysicalactivityorsport-relatedplaytheday of the injuryanduntilahealthcareprofessional,experiencedinevaluatingforconcussion,saysthey are symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first—usually within a short period of time (hours, days, or weeks)—can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain. Members with a concussion should be medically cleared by an appropriate health professional prior to resuming participation in any physical activities or sports-related play. This clearance shall be in the form of a written letter signed by the health care professional. The parent or guardian must provide a copy to the local BTA SUMMER SPORTS CAMPS club before a member can resume physical activity or sport-related play. BTA SUMMER SPORTS CAMPS staff involved in the accident will forward this letter to the main office to be filed with the accident report on this member.
Included in this medical clearance, should be the formulation of a gradual return to play protocol provided by the health care professional.

Care of mildly ill campers

Campers who report not feeling well, such complaints as headache, stomachache, sore throat, etc., will be taken to the designated area for sick campers at the camp. The parent/guardian of the camper will then be contacted for them to be taken home. The ill camper will be supervised by the health care supervisor until the parent/guardian arrives at the camp. In such circumstances where the camper must remain at camp for the remainder of the day, the health care supervisor will ensure that the camper has a quiet area to rest and frequently monitor the camper's condition.

Allergies and Medical Conditions

The camp application requests information on camper's allergies and/or medical conditions. Parents/guardians will be asked to provide the health care supervisor with emergency care plans for those with allergies or medical conditions such as asthma, diabetes, seizures, etc. Such plans should include prevention/care measures, emergency care and emergency numbers for parent/guardians and health care providers.

All staff will be made aware of those campers with allergies, the necessary prevention measures and emergency care. Campers with a prescribed Epi-Pen must have the Epi-Pen with them at all times or with the supervising staff member for that camper.
Staff who directly supervise campers with medical conditions will be made aware of the condition (with parental consent), prevention/care measures and emergency care. Campers with prescribed inhalers for asthma may carry them with them or have a supervising staff member carry the inhaler for that camper. Diabetic supplies may also be carried by the camper and/or supervising staff member for that camper.

Standing Orders: First Aidfor Common Camp Occurrences

First Aid Procedure

1. Abrasions, cuts, lacerations, punctures & scratches

   a. Wash your hands with soap and water or hand sanitizer and put on non-latex disposable gloves
   b. Clean minor injuries thoroughly with plain soap and water and pat dry area with sterile gauze
   c. Cover area with band aid or non-stick sterile dressing

SEVERE BLEEDING: Act fast to control the bleeding

1. Apply firm direct pressure on the wound with a sterile dressing (if available). Do not inspect or remove gauze for 5 minutes to allow for clotting to occur.
2. Elevate injured area above the level of the heart if possible.
3. Apply firm direct pressure to supplying blood vessel if direct pressure to the wound is not successful.
4. Secure a dry sterile pressure dressing- which consists of sterile gauze and a sterile dressing wrapped tightly around the wound and continue to apply pressure if bleeding continues.
5. If bleeding persists call 911 and notify the parent/guardian

Allergic Reaction (Anaphylaxis): A life-threatening allergic reaction (anaphylaxis) can cause shock, a sudden drop in blood pressure and trouble breathing. In people who have an allergy, anaphylaxis can occur minutes after exposure to a specific allergy-causing substance (allergen). In some cases, there may be a delayed reaction or anaphylaxis may occur without an apparent trigger.

Signs and symptoms of anaphylaxis include:

- Skin reactions, including hives, itching, and flushed or pale skin
- Swelling of the face, eyes, lips or throat
- Constriction of the airways, leading to wheezing and trouble breathing
- A weak and rapid pulse
- Nausea, vomiting or diarrhea
- Dizziness, fainting or unconsciousness

Common anaphylaxis triggers:

- Medications
- Foods such as peanuts, tree nuts, fish and shellfish
- Insect stings from bees, yellow jackets, wasps, hornets and fire ants

How to administer Epinephrine Auto Injector (Ep iPen)

1. Immediately call 911 and have another staff notify the parent/guardian
2. If the victim has a prescribed epinephrine auto injector (EpiPen, Auvi-Q, others) to treat an allergic reaction prepare to administer it.
3. Be sure you have the correct medication for the victim, (refer to the instructions on the medication for additional support as the directions vary slightly with different brands).
4. Have the member lay down. If necessary, have another staff hold the leg that you will be injecting. Younger kids almost always need to be held firmly as they will often move or squirm.
5. Form a fist around the pen and pull off the cap on the top of the pen with your other hand.
6. Swing and jab the tip firmly into the outer thigh until it clicks.
7. Hold the pen firmly in the thigh for 10 seconds.
8. Give the EpiPen to EMS when they arrive

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

Staff Information:

Administration of Epinephrine Auto-Injectors Test of Competency Checklist

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

Name: _____

Date of Assessment: _____

Epinephrine Auto-Injector Brand: _____

Checklist	
Steps to Follow:	Check (√)
Demonstrate safe handling, proper storage, and proper disposal of epinephrine auto-injectors.	
Demonstrate the ability to administer an epinephrine auto-injector properly.	
Demonstrate an understanding of signs and symptoms of an allergic 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:

HealthCare Consultant

Name and Title: _____

Signature: _____

Date

Staff
Signature: _____

Date

**An additional injection may be required if symptoms do not improve after the 1st injection is administered and if EMS will not arrive within 5-10 minutes.
**If there are no signs of breathing, coughing or movement, begin CPR.

Animal Bites:

1. Washarea thoroughly with warm water and soap, rinse well with clear running water. a. Apply sterile dressing.
   b. Callparents to have child taken to the health care provider.
   c. Veterinarian should confine and observe animal
   d. If ananimal cannot be found, notify police.

Athlete's foot: Refer to health care provider, do not share footwear.

Blisters:

a. If intact, apply soft absorbent dressing- do not puncture
b. If broken or threaten to break, clean with warm water and soap, apply dry sterile absorbent dressing.

Choking:
If the victim can speak or cough forcibly and is getting sufficient air, do not interfere with his/her attempts to cough the obstruction from the throat. If the victim cannot speak or is not getting sufficient air, have someone call 911 while you perform abdominal thrusts.
The universal sign for choking is hands clutched to the throat. If the person doesn't give the signal, look f

these indications:

- Inability to talk
- Difficultybreathing or noisy breathing
- Inabilitytocough forcefully
- Skin, lipsand nails turning blue or dusky
- Loss of consciousness

choking is occurring, use either the American Heart or The Red Cross approach to caring for a choking victim.
e the technique you have been trained on.

The Red Cross recommends a "five-and-five" app roach

1. Give 5 back blows: First, deliver five back blows between the person's shoulder blades with the heel of your hand.

2. Give 5 abdominal thrusts: Perform five abdominal thrusts (also known as the Heimlich maneuver).
3. Alternate between 5 blows and 5 thrusts until the blockage is dislodged.

The American Heart Association recommends the Heimlich maneuver (abdominal thrust only)

To perform abdominal thrusts (Heimlich maneuver) on someone else >1 year of age:

1. Stand behind the person. Wrap your arms around the waist. Tip the person forward slightly.
2. Make a fist with one hand. Position it slightly above the person's navel.
3. Grasp the fist with the other hand. Press hard into the abdomen with a quick, upward thrust — as if trying to lift the person up.
4. Perform a total of 5 abdominal thrusts, if needed. If the blockage still isn't dislodged, repeat the 5 abdominal thrusts.

f the person becomes unconscious, perform standard CPR with chest compressions and rescue breaths and cal

CPR Differences: Adult and Child- C (c irc ulation), A (Airway), B (Breathing)

	Adult	Child (1 year through the onset of puberty)
Hand Position for Compressions	Ha nds centered on lower half of sternum	Hands centered on lower half of sternum
Rate of Compressions	100–120/minute	100–120/minute
Depth of Compressions	Depth At least 2 inches	About 2 inches
Compression-Ventilation Ratio	1 or 2 rescuers 30:2	1 rescuer 30:2 2 or more rescuers 15:2

**Allow full recoil of chest after each compression; do not lean on the chest after each compression

**Limit interruptions in chest compressions to less than 10 seconds

Airway

To open the airway of an infant, use the same head-tilt/chin-lift technique as you would for an adult or child. However, only tilt the head to a neutral position, taking care to avoid any hyperextension or flexion in the neck. Be careful not to place your fingers on the soft tissues under the chin or neck to open the airway.

Rescue Breathing-

Adult = 1 ventilation (breath) every 5 to 6 seconds

Infant/Child (1 year through the onset of puberty) = 1 ventilation (breath) every 3 seconds

Convulsions/Seizures:

1. Ensure the victim has an open airway- If vomiting occurs, turn victim on their side, wipe mouth and ensure open airway
2. Prevent Injury- Protect the patient from a head injury by lowering them to the ground if there is a chance they will fall. Remove any objects that could cause injury.
3. Call 911, then the parent or guardian

** Do not restrain person having convulsions

** Do not put anything in the mouth of the person having a seizure

** It is not unusual for the victim to be unresponsive or confused for a short time after a seizure.

Earache

1. Take the child's temperature
2. Call the parent to have child seen by health care provider
3. Keep out of water until seen by health care provider

Eye injuries

1. Flush eye with sterile eye solution located in the First Aid kit- unless object is impaled in the eye
2. If eye is scratched or object embedded in eye, place sterile gauze or cup (dependent on object) over eye secured with tape or cling gauze- do not attempt to remove objects imbedded in the eye.
3. Call parent and have child seen by health care provider
4. If serious injury, call 911.

Fainting

1. Have victim lie down, elevate feet higher than head and breathe deeply
2. Provide fresh air, rest and quiet
3. Keep victim resting until fully recovered

**Call 911 if unconscious, otherwise call parent to take home and have seen by health care provider

Fractures

1. Do not move suspected area

2. Do not apply anything to area, except ice if tolerated
3. Call parent for health care provider evaluation
4. If victim must be moved, splint area so that area cannot be moved
5. Cover any open areas with sterile gauze
6. If loss of conscious or signs of shock, call 911 immediately.

**Call 911 if the fractured bone is protruding through the skin or is at risk for breaking through the skin

Headache

1. Take temperature
2. Provide rest and quiet
3. If still persists, call parent

Head injury

1. If victim is unconscious, call 911 and follow American Red Cross for the unconscious victim with suspected head/neck/back injury.
2. If victim is conscious, have him/her lie down
3. Keep victim warm and quiet
4. If they have a wound, cover with sterile dressing
5. Follow the BTA SUMMER SPORTS CAMPS concussion protocol
6. Call parent and have seen by health care provider

Insect bites and stings- Refer to the allergy list. If a child has a known allergy and has a prescription for EpiPen administer the EpiPen according to the health care provider instructions and call 911 immediately

1. For simple bites, cleanse the area with warm soap and water
2. If a bee or wasp bite occurs, remove the stinger using forceps if pulls out easy
3. Apply ice to area

If the child has no known allergy but has trouble breathing, call 911 immediately- do not leave the child alone

Nosebleeds

1. Seatthe victim upright with head slightly forward
2. Pinchthe nostrils for 5-10 minutes and have the victim breathe through their mouth
3. Applyice to the bridge of the nose
4. If bleeding does not stop, is still heavy or reoccurs call parent and have seen by health care provider

Poison ivy, oak and sumac

1. Wash with soap and water
2. Advise parents to apply calamine lotion

Rash- A rash, sometimes called dermatitis, is swelling or irritation of the skin. Rashes can be red, dry, scaly, and itchy. Rashes can include lumps, bumps, blisters, and even pimples. Some rashes, especially accompanied by fever, can be a sign of a serious illness. Hives can also be serious because they can be a sign of an allergic reaction and the camper may need immediate medical attention. Hives appear on a person's body when histamine is released in response to an allergen. The trigger could be a certain food, medicine, or bug bite. A virus also can cause hives.

Common types of rashes:

● Eczema, also called atopic dermatitis, is a common rash for children. Eczema can cause dry, chapped, bumpy areas around the elbows and knees or more serious cases of red, scaly, and swollen skin all over the body. Children who get eczema often have family members with hay fever, asthma, or other allergies. About half of the children who get eczema will develop hay fever or asthma themselves. Eczema is not an allergy itself, but allergies can trigger eczema. Some environmental factors (such as excessive heat or emotional stress) can also trigger the condition.

Irritant contact dermatitis is caused by contact with something irritating, such as a chemical, soap, or detergent. It can be red, swollen, and itchy. Even sunburn can be a kind of irritant dermatitis because it's red and might itch while it's healing.

Allergic contact dermatitis is a rash caused by contact with an allergen. An allergen is something you are allergic to, such as rubber, hair dye, or nickel, a metal found in some jewelry. If you have nickel allergy, you might get a red, scaly, crusty rash wherever the jewelry touched the skin. The most common source of this type of rash is poison ivy.

While other illnesses cause rashes, fifth's disease and hand, foot, and mouth disease are the most common during the summer months.

- Fifth disease is especially common in children between the ages of 5 and 15. Symptoms usually include a distinctive
- red rash on the face that makes a child appear to have a "slapped cheek." The rash then spreads to the trunk, arms, and legs.

  Hand, foot, and mouth (HFM) disease is caused by viruses that live in the body's digestive tract. The virus can spread from person to person, usually on unwashed hands and surfaces contaminated by feces. Children ages 1 to 4 are most prone to the disease. Outbreaks usually occur during the warm summer and early fall months. HFM disease causes painful blisters in the throat, tongue, gums, hard palate, or inside the cheeks. A skin rash with flat or raised red spots can also develop, usually on the palms of the hands and soles of the feet and sometimes on the buttocks.

Care for Rashes:

1. Check to see if the rash is located on one part of the body (localized) or is present on other parts of the body as well (generalized)
2. If the child complains of difficulty breathing, cannot speak or there is swelling of face and/or lips, call 911
3. Keep the area clean, cool and dry
4. If the child complains of itchiness, avoid having scratching.
5. Check for other signs or symptoms of illness such as fever
6. Call parents to have the child evaluated by their health care provider to determine if the rash is contagious

help describe the rash to the parent or health care provider in order to determine if there is a need for exclusion, use this list of estions:

1. Is the rash red?
2. Is it all over the body or only in certain areas?
3. When did it start?
4. Is it getting better or worse?
5. Is the rash flat or bumpy?
6. Are the spots big or little? (such as pinpoint, dime size or various sizes)
7. Are the borders round or irregular and blotchy?
8. Are there blisters?
9. Is the rash itchy? (in an infant this may be observed as irritability)
10. Has there been a fever or other symptoms?
11. Has anyone else at home had similar symptoms recently?

- Shock- Shock may result from trauma, heatstroke, blood loss, an allergic reaction, severe infection, poisoning, severe burns or other causes. When a person is in shock, his or her organs aren't getting enough blood or oxygen. If untreated, this can lead to permanent organ damage or even death.

Signs and symptoms of shock varydepending on circumstances and may include:

1. Cool, clammy skin
2. Pale or ashen skin
3. Rapid pulse
4. Rapid breathing
5. Nausea or vomiting

6En. larged pupils

7. Weakness or fatigue
8. Dizziness or fainting
9. Changes in mental status or behavior, such as anxiousness or agitation

Call 911 If you suspect a person is in shock. Then immediately take the following steps:

1. Lay the person down and elevate the legs and feet slightly, unless you think this may cause pain or further injury.
2. Keep the person still and don't move him or her unless necessary.
3. Begin CPR if the person shows no signs of life, such as breathing, coughing or movement.
4. Loosen tight clothing and, if needed, cover the person with a blanket to prevent chilling.
5. Don't let the person eat or drink anything.
6. If the person vomits or begins bleeding from the mouth, turn him or her onto a side to prevent choking, unless you suspect a spinal injury.

Sore throat

1. Checktemperature
2. Checkthroat
3. Call parent to take home or have seen by health care provider

Sprains and strain s

1. Elevate the injured area and provide complete rest to the area
2. Apply ice and compression (ace bandage) to minimize swelling and pain
3. Call parent and have seen by Health Care provider for diagnosis and treatment

Stomach aches or upset stomachs

1. Take temperature
2. Provide rest/lie down
3. Call parent to take child home, if severe have seen by health care provider

Sunburn

1. If mild, apply cold compresses
2. If severe, refer to health care provider

Sunstroke

1. Take victim indoors or to a shady area
2. Have them lie down on back, feet slightly elevated
3. Loosen any tight clothing,
4. Apply cold compresses to head and behind neck
5. Cool body with tepid water
6. If victim is conscious, have them sip water
7. Call parent, and refer for emergency treatment

Toothache

1. Call parents to have seen by dentist

Tooth Avulsion (a complete displacement of a tooth from its socket- Permanent Teeth only!)

1. Keep the patient calm Find the tooth and pick it up by the crown (the white part)- avoid touching the root If the tooth is dirty, wash it briefly (10 seconds) under cold running water Assist/encourage the patient to replant the tooth into the socket and have them bite on a handkerchief to hold it into position. If this is not possible then place the tooth in a suitable storage media for an avulsed tooth
2. Storage solutions for a tooth avulsion: Hank's Balanced Salt Solution (containing calcium, potassium chloride and phosphate, magnesium chloride and sulfate, sodium chloride, sodium bicarbonate, sodium phosphate dibasic, and glucose), propolis, egg white, coconut water, Recital, or whole milk. Avoid storage in water!

5. Seek emergency dental treatment immediately.

Vomiting

1. Have victim rest
2. Ensure the victim will not choke on vomit- sit up and lean forward
3. Do not feed milk products or solid foods to a child who has been vomiting
4. Give small amounts of fluid if tolerated
5. Call parents to have child taken home, see health care provider if necessary

Exclusion from Camp due to Illness

Campers may not attend or will be sent home from camp for the following:

1. Illness that prevents the child from participating comfortably in activities.
2. Illness that results in a need for care that is greater than the staff can provide without compromising the health and safety of other children.
3. An acute change in behavior - including lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash.
4. Fever (temperature above 101°F [38.3°C] orally or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea).
5. Diarrhea- defined by watery stools or decreased form of stool that is not associated with changes of diet. (Depending on the cause of the diarrhea, a note from the child's health care provider may be required to return to the program).
6. Blood or mucus in the stools not explained by dietary change, medication, or hard stools.
7. Vomiting more than 2 times in the previous 24 hours.
8. Abdominal pain that continues for more than 2 hours or pain associated with fever or other signs or symptoms of illness.
9. Mouth sores with drooling- unless the child's primary care provider states that the child is noninfectious.
10. Rash with fever or behavioral changes- until the primary care provider has determined that the illness is not an infectious disease.

*** Indicates a note from the child's health care provider is needed upon return to the program.*
Children placed on antibiotics should be on them for 24 hours before returning to camp.

Plan for infectious spills control and monitoring

1. Any camper or staffmemberthat has signs and symptoms of illness and/or infectionwillbe sent home and advised to seek a medical evaluation from their health care provider for diagnosis and treatment.
2. Increased prevalence of illness or symptoms of food poisoning such as fever, rash, diarrhea, sore throat, vomiting or jaundice will be reported to the Camp Director. The Camp Director will then inform the local board of health and the Massachusetts Department of Public Health.
3. Facilities and supplies will be available for proper hand hygiene as well practice of proper hand hygiene by all campers and staff.
4. All areas used for eating will be cleaned with soap and warm water after eating.

Procedures for the cleaning up of blood spills

1.Non-latex disposableglovesmust bewornin additiontoanyothernecessary personal protective equipment needed to protect the individual responsible for cleaning the blood spill from bloodborne 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).

4. 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.
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.

Storage and Administration of Medication

105 CMR: 430.160

Medications will 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.

Administering medications (prescription and non-prescription)

The healthcaresupervisor will administeronly oral and/or topicalmedications, or Epi-Penwhen appropriate (see allergies and medical conditions). The health care supervisor will or has receive(d) training on proper medication administration. There will be documentation of the training and competency of each health care supervisor trained and designated to administer medication at their respective camp sites. The Health Care Consultant will be given a copy of the documentation of the training contents.

Before any prescription medication(s) will be administered at camp the following conditions must be met:

1. A signed authorization form by the parent or guardian to give their child medication(s) while at camp.
2. A signed written medication order by the camper's licensed prescriber (physician, nurse practitioner or physician assistant). One form should be filled out for each medication to be administered at camp.
3. All prescribed medication(s) given at camp must be in their original pharmacy bottle/container which must contain on the original pharmacy label including:
   a. Pharmacy name and address
   b. Serial number of the prescription
   c. Refill number
   d. Name of licensed prescriber
   e. Name of child receiving medication
   f. Name of prescribed medication
   g. Directions for use and cautionary statements, if any
   h. Dose and time(s) of medication
   i. Original prescribed date
   j. Discard (expiration)date
   k. If tablets or capsules, the number in the container.
   l. All non-prescription medication(s) must be in their original package.

The Health Care Consultant will review and sign off on any medication to be given during summer camp.

The health care supervisor will accept the delivery of medication and ensure that all proper documentation is in place before administering medication(s).

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 D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

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,

follow certain procedures to ensure minimum safety requirements are met (105 CMR 430.000: *Minimum*

If your child may require any medication during their time at camp, Massachusetts regulations require the camp to

S(*t*Sa*t*n*ad*te*a rSd*as*n *fio*ta*r* r*Rye* C*croe*d*a*e*t,i o*C*n*ha*al*p *Cta*er*m* I*p*V*s*) *f*)*o*. *r*T *Ch*he *iald*tr*t*a*ecn*hed consent form gives the camp permission to store and administer medication to the camper by certain trained camp staff. The criteria you• t o c**l**a**f**r **p**e**r**fu**o**l**v**l**yid** r**ie**n**v**g**i**e **p**w**r e**th**sc**e**r**si**e**p** c**t**ri**i**o**t**n**e**r **m**i**a e**a**d**n**i**d**c a**dt**i**i**s**o**c**n**u**s**s**s f o**an**r** y**t h**s**e**p e**cc**a**i**m**fi**c**p** q **t**u**c** below explain the requirements for those medications and the procedures the camp must follow. It is important for **attached form "Authorization to Administer Medication to a Camper" completely.**

- **Medication that will be administered at camp must be provided by the parent/guardian to the camp in the original container(s) bearing the pharmacy label with the following information:**

o Specify "NA" – Not Applicable, where appropriate.
o Be sure to sign the form.
o

the date of filling

o the pharmacy name and address o the filling pharmacist's initials o the serial numberofthe 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

480-1•8 -AdMVIesodriyc –a tPIaorennist /mGuuasrut Ibane A suttonIroeridza taiot nc taom Adpm iinn iast esre Mcuedrieca ltoiocna ttoi ao Cna.m p

- **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

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

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

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

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

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

Administration of Prescription Medication

Test of Competency Checklist

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

Health Care Supervisor's Name: _____

Date of Assessment: _____

Medication Name(s): See attached list

Route: □ Drops: eye, ears, nose □ □Topical □

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:

HealthCare Consultant

Name and Title: _____

Signature: _____

Date

Health Care Supervisor

Signature: _____

Date

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

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

Ihereby 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:

Ihereby 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).**

1M**05**e d**C**ic**M**a**R**tio **4**n**3 0s.**h**1**a**6**l**0**l **(**o**C**n**)l:**y be administered by the health care supervisor or by a licensed health care professional authorized to administer p 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.

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	
	Any Problem or Uncertainty	
3. Limits of the Health Care Supervisor: Reports		
	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 3. Select and Read Label of Medication 4. Observe Student Prepare and Take Medication 5. Replace Medication in Secure Location 6. Lock or Secure Location 7. 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	
	Camp's Emergency Plan and when to call Emergency Services Review	

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.**

Documentation of Medication Administration:

A medication administration record will be kept for each camper that receives medication during camp hours. This record will include:

1. A daily medication log, including the medication order and parent/guardian authorization.

The daily log shall contain:

1. The dose or amount of medication administered.
2. The date and time of administration or omission of administration, including the reason for omission.
3. The full signature of health care supervisor administering the medication. If the medication is given more than once by the same person, he/she may initial the record, subsequent to signing a full signature.
4. All documentation shall be recorded in ink and shall not be altered.

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: _____

Medication Administration Log

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

Reporting and Documentation of Medication Errors

A medication error includes any failure to administer the medication as prescribed for a particular campe
including failure to administer the medication:

1. Within appropriate time frames (The appropriate time frame should be addressed in the medication administration plan.)
2. In the correct dosage
3. In accordance with accepted practice
4. To the correct camper

In the event of a medication error, the health care supervisor must notify the parent or guardian immediately. (The health care supervisor will document the effort to reach the parent or guardian.) If there is a question of potential harm to the student, the health care supervisor will also notify the camper's licensed prescriber or the camp's health care consultant. The Camp Director is to be notified of the situation and status.
The health care supervisor on BTA SUMMER SPORTS CAMPS incident report form will document medication errors. These reports will be retained in the camper's health record. They will be made available to the Department of Public Health and Inspectional Services Department (City of Boston) upon request. All medication errors resulting in serious illness requiring medical care will be reported to the Department of Public Health, and Inspectional Services Department (City of Boston). All suspected diversion or tampering of drugs will be reported to the Department of Public Health, Division of Food and Drugs. For serious illnesses from medication errors a DPH Recreational Camp Injury Report should also be completed according to the injury report guidelines.

Self-Administration of Medications

"Self-administration" means that the camper is able to consume or apply medication in the manner directed by the licensed prescriber, without additional assistance or direction.
Acampermayberesponsiblefortakinghis/herownmedicationafterthefollowingrequirements are me

1. The camper, health care supervisor and parent/guardian, where appropriate, enter into an agreement, which specifies the conditions under which medication may be self- administered.
2. The health care supervisor, as appropriate, develops a medication administration plan, which contains only those elements necessary to ensure safe self-administration of medication.
3. The camper's health status and abilities have been evaluated by a licensed prescriber who then deems self-administration safe and appropriate. As necessary, the health care supervisor shall observe self- administration of the medication.
4. The camper is able to identify the appropriate medication, knows the frequency and time of day for which the medication is ordered.
5. There is written authorization from the camper's parent or guardian that the student may self- medicate.
6. The licensed prescriber provides a written order for self-administration and the camper follows a procedure for documentation of self-administration of medication.

Storage of Medication

All medications will be stored in their original pharmacy or manufacturer labeled containers and in such a manner as to render them safe and effective. Expiration dates shall be checked.

All medications to be administered at camp shall be kept in a securely locked affixed cabinet used exclusively for medications. Medications requiring refrigeration will be stored in either a locked box in a refrigerator or in a locked refrigerator maintained at temperatures of 36 to 46 degrees Fahrenheit

Returning or Destroying Medication

Any unused, discontinued or outdated medications shall be returned to the parent or guardian as soon as possible. If the medication cannot be returned, it shall be destroyed as follows:

1. Destruction of prescription medication shall be accomplished by the health care supervisor, witnessed by a second person and recorded in a log maintained by the camp for this purpose. The log shall include the name of the camper, the name of the medication, the quantity of the medication destroyed, and the date and method of destruction. The health care supervisor and the witness shall sign each entry in the medication destruction log.

The medication log shall be maintained for at least three years following the date of the last entry.

Camps should train staff members so they can help with the following diabetes care:

- Blood glucose monitoring: If blood glucose (sugar) is out of target range, a child may be at risk for both short-term emergencies and long-term complications. Some children cannot self-test blood glucose and would need help from a staff member.
- Insulin administration: This can be either through injection by a syringe or pen, or through an insulin pump. The standard of care for children with type 1 diabetes is to give them multiple daily dosages of insulin, either through injection or through the pump.
- Glucagon administration: If a child experiences very low blood glucose (hypoglycemia), an injection of glucagon can save his or her life. Glucagon is a rescue medicine that must be used right away. Staff should be trained to use this life-saving medication.

All staff members responsible for children with diabetes should be trained to know the warning signs of low and high blood glucose (hypoglycemia and hyperglycemia) and know how to help.

The signs of hypoglycemia (low blood sugar) include:

- Shakiness or dizziness
- Nervousness or sweating
- Hunger
- Headache
- Pale face

- Anger, sadness, confusion, stubbornness or crankiness
- Fainting or clumsiness
- Tingling feeling around mouth
- Seizure

The signs of hyperglycemia (high blood sugar) include:

- Frequent urination
- Extreme thirst
- Feeling weak or tired
- Blurry vision or can't see clearly

EMERGENCY/MEDICAL FACILITIES AND EQUIPMENT

105 CMR: 430.161

There will be a designated space for ill or injured campers to be treated with any first aid needs. This location should include space for a child to rest, have privacy during treatment, and a space to isolate a child suffering from an illness that may be a communicable disease. There will be two locations: 1. The nurse's office in the Main Building, 2. The Athletic Trainer's room located in the Indoor Athletic Facility (IAF).

First aid kits are adequatelystockedby the school's athletic trainer BUT maintained by the Health Care Supervisor. Only staff members who are CPR and first aid certified will administer first aid. All first aid administered will be recorded in the Medical Log. First Aid Kits will be filled to the new American National Standards Institute Z308.1 2015 standards listed below:

ANSI 2015	Minimum Size or Volume

Class A Kits		Class B Kits	US	Metric
Adhesive Bandage	16	50	1 x 3in	2.5 x 7.5cm
Adhesive Tape	1	2	2.5yd (total)	2.3m
Antibiotic Application	10	25	1/5o7z	0.5g
Antiseptic	10	50	1/5o7z	0.5g
Breathing Barrier	1	1	-	-
Burn Dressing (gel soaked)	1	2	4 x 4in	10 x 10cm
Burn Treatment	10	25	1/3o2z	0.9g
Cold Pack	1	2	4 x 5in	10 x 12.5cm
Eye Covering (with means of attachment)	2	2	2.9sq in	19sq cm
Eye/Skin Wash (1fl oz. total)	1	-	-	29.6
Eye/Skin Wash (4fl oz. total)	-	1	-	118.3ml
First Aid Guide	1	1	-	-
Hand Sanitizer	6	10	1/3o2z	0.9g
Medical Exam Gloves	2pai r	4pair	-	-

Roller Bandage (2in)	1	2	2in x 4yd	5cm x 3.66m
Roller Bandage (4in)	-	1	4in x 4yd	10cm x 3.66m
Scissors	1	1	-	-
Splint	-	1	4 x 24in	10.2 x 61cm
Sterile Pad	2	4	3 x 3in	7.5 x 7.5cm
Tourniquet	-	1	1in (wide)	2.5cm (wide)
Trauma Pad	2	4	5 x 9in	12.7 x 22.86cm
Triangular Bandage	1	2	40 x 40 x 56in	101 x 101 x 142cm

PROTECTION FROM SUN AND TOBACCO

105 CMR: 430.163

Exposure to the sun is potentially damaging. Campers and Staff will be encouraged to use sunscreen of 30 SPF or higher and other medication like zinc oxide ointment before exposure to the sun. Limit on exposure to the sun by a child should be discussed with parents/guardians if indicated. A notation should then be made to the child's file.

If over exposure to the sun is evident, first aid procedures for the condition will be followed and administered by first aid certified staff members or the health care supervisor. The health care supervisor will record the instance in the Medical Log and will notify the parent either by phone or by sending a note home with the camper.

TOBACCO USE

105 CMR: 430.165

The Brookline TennisAcademy is a non-smoking campus and BTA Summer Sports Camps has a complete no tobacco use policy. Staff are informed during the interview process and orientation that no use of tobacco, including nicotine delivery systems (e-cigarettes, vaporizers, etc.), are allowed at the camp.

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

CHARLES D. BAKER
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KARYN E. POLITO
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Reducing Risk of Mosquito-borne Illness While Outdoors Guidance for School Staff: Applying EPA- Approved Mosquito Repellent to Preven t EEE

2021islikely tobe the third year ofanEEE outbreak cycleinMassachusetts,andthere w
However, children cancontinue to send time outdoors for recess

probablybe some risk topeople.

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.

in any age group; however, EEEcan causesevere illnessandpossiblyleadtodeath peopleunder age15areat particularrisk.

To reduce the chance of becoming infected, the Department of Public Health (DPH) recommends always applyinganEPA-approved mosquitorepellentto children before th
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 consideredadrugor medication, they are not subject to 105 CMR 210, and thus schools are *not* limited to onlythoseschool staff who are designated by the school nurse as staff authorized to administer medications.Schoolsshould identify staff that can:
    - follow the procedures laid outintheseguidelines
    - read and understand the applicationinstructions listed on the repellent
    - communicate with students, and
    - monitor a student to identify adverseeffects, such as a rash.
- Staff should wash their hands beforeandaftereach application (do not wear gloves).
- Parents/Caregivers should be notifiedofanyschool-supplied repellent and be given the option to opt out of having repellent applied to their child.
- Parents/Caregivers can provide theirownrepellent to be applied to their child, however, Parents/Caregivers need to communicatewiththe school in regards to any repellent being sent in for their child, so that school staff may labelandsafelysecure the repellent.
- Follow safe storage guidelines; schoolshouldstore insect repellents safely out of the reach of children, such as in a
  locked cabinet out of the reach of smallchildren.[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

GENERAL PROGRAM ACTIVITIES & DISCIPLINE

105 CMR: 430.190

Parents complete authorizations for each camper including: people authorized by the legal guardian to drop off/pick up their children and method of arrival and dismissal. Parents will submit a form for campers walking home within a specific distance set by BTA Summer Sports Camps. Legal guardians will be called if campers do not arrive at the start of camp, and parents are directed to call BTA Summer Sports Camps if campers do not arrive home within 10 minutes of schedule. Staff monitor arrival and dismissal for camper safety and instruct drivers and walkers in safe practices such as use of crosswalks, and allowing campers to only exit vehicles on the sidewalk.

Any promotional literature or brochures will state, *"This campmust comply withregulationsof the MassachusettsDepartmentofPublicHealthandbe licensedby thelocal boardofhealth."*

Prior to their child attending camp, a parent/guardian will receive a parent handbook that will review pertinent camp policies including but not limited to background check, health care and discipline as well as procedures for filing a complaint. In addition, the parent handbook includes policy for mildly ill campers, emergency medical releases, and medication administration policy. The parents are notified that they may request copies of background check policies, heath care and discipline policies.

If a child arrives at the camp who is not registered and the camp is unfamiliar with, every effort will be made to locate the child's parents/legal guardian. If this is unsuccessful, the proper authorities will be notified. While this process is occurring, the child may receive a snack or meal, but will not be allowed to participate in activities at the camp.

If an unknown adult arrives at the camp, the camp staff will attempt to identify that person and will assess if they have a legitimate reason to be on the campus. If they cannot be identified or do not have a legitimate reason to be there, the leadership will ask them to leave the premises. If they are uncooperative the police will be called.

DISCIPLINE POLICY

105 CMR: 430.191

The following discipline is reviewed at staff orientation and parents are provided with a copy of our discipline policy. Parents are asked to support the staff in our efforts to foster a safe, positive environment for the campers.

At Brookline Tennis Academy Sports Camps, we abide by the 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 Brookline Tennis Academy Summer Programs are a part of that community. The 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, Brookline Tennis Academy 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

Brookline Tennis Academy Summer Sports 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 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 growth as a person, and their long-range happiness and welfare.

StaffResponsibility

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. Brookline Tennis Academy Summer Sports Camps reserves the right to skip any one of the steps if the situation warrants

- Staff will redirect the child to more appropriate behavior.
- 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.
- In the event of continuing or more severe misbehavior, staff will document the situation using a Camper Log in with the 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.
- If the behavior persists, a parent will be notified (by phone or in person) of the problem by the camper's Head Counselor. The Head Counselor will consult with their Camp Director prior to placing the call home.
- (*Note*: Pick-up and drop-off are generally not appropriate times for this type of communication with parents)
- If warranted, the camp director will schedule a conference with the parent so they can determine the appropriate action to take.
- 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.
- 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.
- 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.

- If a problem persists and thechild continues to disrupt the program, Brookline Tennis Academy Summer Sports Programs reserves the right to dismiss the child from the program. Decisions regardingdismissal shall be made in conjunction with the Camp Director.

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

- 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

PLAYGROUND & ATHLETIC EQUIPMENT & FACILITIES

105 CMR: 430.206 – 430.207

Athletic Equipment and Facilities Requirements Policy – Storage & Operation of Power Equipmen t

All equipment associated with the sports programming will be set up and maintained in accordance with the manufacturer's standards. The portable equipment will be monitored daily by the Athletic Instructors. Any equipment that is in disrepair will either be repaired or replaced.

The equipment that needs to be distributed will do at the beginning of the day and collected at the end of the day by the camp staff.

All playing fields and courts will be kept free from holes and other obstructions which may cause an accident.
Power equipment will not be used by the campers, at any time. Power equipment will be stored in a locked place whenever not in use. Power equipment will not be stored, operated, or left unattended in areas accessible to campers without proper safeguards.

TELEPHONE POLICY

105 CMR: 430.209

The camp has a number of reliable phones available throughout the facilities that can be used in the event of an emergency. An emergency phone number list will be posted near designated telephones. The list will include the number of the health care consultant, police, emergency medical services and fire department.

Appendix I: Sample Phone List

EMERGENCY AND CONTINGENCY PLANS

105 CMR:430.213

BTA Summer Sports Camps has a contingency plan including but not limited to the following emergencies: Fire, Disasters, Lost Camper, and Traffic Control.

FIRE DRILL

105 CMR: 430.210

There will be a fire drill within the first 24 hours of the beginning of each session. The fire evacuation plan will be reviewed and approved by the local fire department. The evacuation plan will be reviewed and practiced during staff orientation. (See also Fire Prevention Policy 105 CMR: 430.215.)

Appendix J: Fire Drill Form

CRISIS PROCEDURES

105 CMR: 430.211

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

EVACUATION PROCEDURES

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

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

- All campers and staff must leave the building immediately and gather in designated areas, by

  camp group, in the parking lot adjacent to the main entrance to the school off of St. Theresa Avenue.

- Counselors and Junior Counselors will take attendance of campers in their particular groups, and report any absence (other than campers not in camp that day) to the camp director or his designated representative.
- Campers should remain quiet at all times. No one will reenter the buildings until
- the Camp Director (or his designated representative) gives permission to do so.
  PROCEDURE FOR A "TAKING REFUGE" RESPONSE ON CAMPUS

In the event of a serious (but not immediate) outside threat to the safety of the school community (e.g., a military/terrorist attack on Greater Boston, hazardous weather, or direction from local law enforcement), campers, faculty, and staff should immediately proceed with the procedure per the guidelines listed below:
The signal is REPEATED SHORT RINGS of the school bells: 2-2-2-2 and also a NOTICE

VIA THE SCHOOL -WIDE PHONE INTERCOM.

- All campers and staff who are in the Jarvis Refectory, Smith Art Center, and Bauer Science Building should proceed to the Smith Theater and gather in designated areas, by group level.
  All campers and staff located in the Ernst, Gordon, Perry, or Athletic Wings, including the Indoor Athletic Facility, should proceed to Rousmaniere Hall and gather in designated areas, by group level.
  Counselors (or junior counselors) will take attendance of campers in their
- particular groups, and report any absence (other than campers not in camp on that day) to the Camp Director or his designated representative.
  Campers should remain quiet at all times. All campers and staff must remain in the assigned gathering places until the Camp Director or his designated representative
- gives further direction.
  PROCEDURE FOR A "LOCK DOWN" RESPONSE ON CAMPUS

-

The signal for a Lock down is a 15 SECOND CONTINUOUS RINGING OF THE BELLS and also A NOTICE VIA THE SCHOOL-WIDE PHONE INTERCOM.

- When the signal sounds, all campers and staff should proceedtothe nearest classroom or office. The classroom or office door should thenbelocked. An adult should be present in each occupied room. Campers and staffshould position themselves in the room in a way that prevents their being seenthrough windows. So as not to attract attention, there should be no talking or noise-making. All lights should be turned off and the shades drawn. A message via theschool-wide intercom system may provide further instructions. All campers and staffmust remain in place until given other directions by a law enforcement or schoolofficial.

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.

MISSING CAMPER PROCEDURES

105 CMR: 430.212

The staff should regularly take a count of campers for whom they are responsible, particularly when moving from one area of camp to another. In addition to head counts, staff will institute a "buddy" system and ask campers to keep track of their buddy when moving place to place. If you discover a camper is missing, follow these procedures:

- Report the missing camper to the Camp Director or Supervisor of the group with the following information:
  - Campers name, age, sex o Last place the camper is seen
  - oW hat was the camper wearing? (color and style, type of shirt, shorts, pants, etc.) o Other information that could be helpful (height, hair color and style)
- Retrace the group's steps. If unsuccessful, notify the office. Meanwhile:
- 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 will sound Air Horn then 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.

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

Traffic Control:

At all times when campers leave BTA Summer Sports Camps they will do so as a group and the following procedures will be implemented:

Staff will take particular care as campers are dismissed at the end of the day as they greet those who are meeting them. All measures will be taken to secure safe passage of campers and staff.

Vehicle Drop off/pick up Parents receive details including safe drop off and pick up procedures.

Appendix K: Campus Map with entrance and exit locations. Drop off locations are highlighted as well.

DAY CAMP CONTINGENCY PLANS

105 CMR: 430.213

Only campers who are enrolled in camp will be allowed to attend BTA Summer Sports Camps.

Before the beginning of each session, a camp roster/list of children is generated and submitted to the Clinic Director. The Clinic Director will check the list on a daily basis to ensure everyone is accounted for. Clinic Directors will take head counts throughout the day to ensure campers are accounted for.

From 8:30a.m. to 9:00 a.m., the campers arrive at camp. Each morning, a staff person will greet the children to ensure a parent or authorized adult is dropping them off. Once a camper is signed in, an BTA SUMMER SPORTS CAMPS counselor will escort them to the right area for their activity.

By 9:30 a.m. the Camp Director should begin to telephone all campers with unexplained absences. The cellular phone number will be called first. If a machine answers, a message is left stating the camper is absent. Next, the parent/guardian's work number is called and if the parent/guardian is not available, a message is left to call BTA Summer Sports Camps immediately.

By 3:45 pm the Camp Director should begin to telephone all campers that are not pre-registered for the extended day program. The cellular number will be called first. If a machine answers, a message is left stating the camper is has not been picked up. Next, the parent/guardian's work number is called and if the parent/guardian is not available, a message is left to call The BTA Summer Sports Camps as soon as possible. At this point the emergency contacts are called.

By 4:30, if a camper has not been picked up, the Camp Director will notify the members parent/guardian at cellular number first. If no one answers, next the work phone number is called, and if the parent/guardian is not available a message is left to notify The BTA Summer Sports Camps as soon as possible. At this point emergency contacts are called. If all phone numbers are unsuccessful, Camp Director may call the authorities.

If a camper who attended the program does not arrive for dismissal, Camp Director will implement lost camper procedures (see lost camper policy).

Any child who arrives at camp and is not registered to attend will be brought into the BTA Summer Sports

Camps office. Every effort will be made to contact the child's parents or guardians to inform them that their child will not be allowed to attend the camp. If no parent or guardian can be reached, the Camp Director will be notified and if necessary, authorities will be called.

EMERGENCY COMMUNICATION SYSTEM POLICY

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. For missing camper procedure, Camp Director will sound air-horn to communicate camp wide procedure. Other camp procedures are communicated through school bells and school-wide phone intercom.

STORAGE OF HAZARDOUS MATERIALS

105 CMR: 430.214

Storage of Gasoline and Flammable Substances

All flammable materials will be plainly marked and stored in a locked building not occupied by campers or staff and located at a safe distance from other buildings. Campers will not have access to the buildings or materials.

Storage of Disinfectant and Other Hazardous Chemicals

All containers for insecticides, disinfectants and other hazardous materials will be plainly marked and kept in a locked storage closet. The closet will be separate from where food is stored and no campers will have access to the closet.

FIRE PREVENTION

105 CMR: 430.215

BTA Summer Sports Camps will take every precaution to reduce the risk of fire:

- No smoking signs, and evacuation routes and signs will be posted throughout the buildings.
- All flammable liquids will be stored in approved containers away from combustibles.
- Trash will be removed on a regular basis.
- Corridors and doorways will be kept free of obstructions. Fire detection and alarm systems will be tested on a regular basis.
- There will be a fire evacuation director, an assistant evacuation director and three search monitors. If applicable, assistants will be assigned to any physically disabled people on

site. The search monitors willclose but not lock all interior doors after searching each room.

- A fire drill will be conducted during the first day of camp each session. There will be one fire drill per session.

Appendix L: Fire Inspection Certification for camp

Inspection Form

105 CMR 430.000: MINIMUMSTANDARDSFORRECREATIONALCAMPS FOR CHILDREN
(STATE SANITARY CODE, CHAPTER IV)

Agency Name

Phone Number

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

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:

(STATE SANITARY CODE, CHAPTER IV)

InspectionForm

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN
(STATESANITARYCODE,CHAPTERIV)

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

marked below indicates a violation of 430.000

"No" column =

marked below indicates compliance with the provision of 430.000

"Yes" column =

"N/A" column = marked below indicates the provision of 430.000 is not applicabletothiscamp

Regulation – 105 CMR 430.0 00		Yes	NoN/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) • Out-of-state/International criminal background checks available (as needed)				# CORI Viewed_____ # SORI Viewed_____
.090(D)	Volunteer(s) • CORI and SORI reports available/stored securely • Previous work/volunteer history (minimum 5 years)				# CORI Viewed_____ # SORI Viewed_____

	• Out-of-state/International criminal background checks available (asneeded)				
.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)

CAMPPOLICIES - 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 (STATESANITARY CODE, CHAPTERIV)

	FIELD TRIPS				
.212(A)	Written itinerary provided to Parents/Guardians and means to notify Parents/Guardians of changes to itinerary before departure Minimum 1 health care supervisor (HCS)				
.212(B)	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 campcoach, director, etc. camp vehicles maybe used • >14 passengers, vehicle must beschool bus • RMV compliant w/ annual safety inspection				
.251(C)	Seatbelts must be worn				
.251(D)(E)	1 staff/volunteer required when transporting: • • C rs to the pick-up/drop-off site • 8+ pers under 5 yrs. of age 2+ pers with physical handicaps				
.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 Requireme nts					
.102(A)	Residential2:5 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) .102(D)	: 25 yrs.+ and proof of Primitive, Travel, Trip experi ence supervising children in similar activities				
Counselors/JuDneisoirgCnoautendseSluobrss:titute:					
.100(C)(2) .100(A)(B)	Day Camp, Non-Sport *Counselor*= 16 yrs.+ OR *Junior Counselor*=15 yrs.+ • 4+ weeks experience and attend orientation/required training(s)				
.100(C)(1) .100(A)(B)	Residential, Primitive, Sport, Travel, Trip, Medical Specialty Camp: *Counselors* = 18 yrs.+ or graduated from high school OR *Junior Counselors* = 16 yrs.+ • 4+ weeks experience and attend orientation/required training(s)				

Required Ratio of Counselors to Campers:					
.100(C)(3)	All counselors 3 yrs. older than campers				
.101(A)	**Residential / Day / Sports Camps**: 1 counselor per 10 campers 7 yrs.+ 1 counselor per 5 campers under 7 yrs. Jr. counselors supervise 50% of counselor ratio and always under direct supervision of counselor				
.101(B) **.159(C)**	**Primitive / Travel / Trip Camps**: 1 counselor per 10 campers • 1 counselor 21 yrs.+ • 2 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				

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,orTripCamp: • Medical history signed by health care provider • Physical within 18 months				
.151(B)	Day Camp: Medical history signed by Parent/Guardianor health care provider				
IMMUNIZATIONS					
.152	Campers/Staff under 18 yrs. **Refer to annual memo*				Number of Records Checked: _____
.152	Staff 18 yrs.+ **Refer to annual memo*				Number of Records Checked: _____
.153	Exemption Documentation				
CAMPACTIVITES					
.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: • hFiaezladrsd/ss urfaces free of holes/accident • No concrete under/around securely anchored playground equipment Pliable or canvas swing seats •				
SPECIALIZEDHIGHRISK 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 Activi ties		Aquatics Director Name:			
.020 .103	Camps that provide onsite aquatics activities shall have an aquatics dire 21 supervisory position) (Lifeguard certificate, previous experience				
.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

105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN

(STATE SANITARY CODE, CHAPTER IV)

SWIMMING					
.430	MA Swimming Pool in compliance with 105 CMR 435 .000 (Permit Posted) and compliant with VGB andA ct pool fence requirements				
.432	MA Bathing Beach in compliance with 105 CMR 445 .000. Beach signage, weekly water sampling, suff icient water clarity, and ring buoy Camp in compliance with 105 CMR 432.000 (Christian's Law) and M.G.L. c. 111 § 127A ½				
.204(B)	Swim test to classify swimmers by ability at pools and beaches (Christian's Law)				
.204(B) .103 .)24 0340(CB)	Proper supervision at swimming venue: • 1 lifeguard per 25 campers • 1 counselor per 10 campers • Plan to check swimmers - "buddy system" • 50+ kidsin/near waterAquaticsDirectorpresent				
.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 per25 campers • 1 properly trained counselorper10campers				
.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 ory 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: • nselors in separate watercrafts • previous with experience • more difficult than Class III, no assified • ers N ng/motor- powered activities in hazardous • conditions certified with ARC Level 4+ Certificate				
.103(B)(6)	Written boating safety plan including procedures for 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 counselorper10campers				

.201(A)	Firearms in good condition, stored in locked cabinet. Ammunition locked in separatecabinet				
.201(B)	Shooting range away from other activityareas				
.201(C)	Only non-large capacity, single shot rifles permitted				
.201(D)	Firing line in place, no crossing without instructor's permission				
.201(E)	Personal weapons allowed with camp operator's written permission				
.203					
ARCHERY					
.103(E)	1 counselor per 10 campers at the range at all times				
.202(A)	Equipment in good condition, stored locked Range away from other activity areas, clearly marked danger area with 25 yards clearance behind each target, common firing and ready line in place				
.202(B)	Personal weapons allowed with camp operator's written permission				
.203					
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 maintainedin accordancewith 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				
.370(C)(D)	Toilets located less than 200 ft from sleeping rooms, all windows/openings screened, and screen doors equipped with self-closing devices				
.372	Operator shall provide at all toilets/handwash sink a supply of toilet paper, soap, hand drying method, 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: 111200°°FF -				
.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 Adequate and centralized				
.300(B) .304	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				
.450	cSaitme pers/staff and eloliccaitt iao np redetermined response requirements: • Accessible atalltimes • Surface drainage and traffic conditions do not cause undue hazards •Watersupply/sewagedisposal facilitiesare 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				
FOODSERVICE					
.320	Food service in compliance with 105 CMR 590 with UfoSodD pAe rSmuitm prmomeirn ently displayed. 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,TripCamps–Provideat least 3 nutritious meals per day which mreeceotms mended 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 Lighting provided in kitchen and dining area				
.453	Sleeping prohibited in food areas				
.471					

MAINTENANCEOFRECORDS					
.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 ItineraryForm

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	
Addressof Trip	# and Street	Neighborhood or City	State	Zip
Telephone of Location		Website of Location		
Departure fromSite Time		Return to Site Time		

Method of Transportation	
Special Notes to Parents	

Program/ Staff Information

NameofGroupattendingFieldTrip/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
ExecutiveOffice ofHealthand 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
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Reducing Risk of Mosquito-borne Illness While Outdoors

Guidance for School Staff: Applying EPA- Approved Mosquito Repellent to Prevent

2021islikelytobethethirdyearofanEEEoutbreakcycleinMassachusetts,andtherewillprobablybe so
Howver, children can continue to spend time outdoors for recess and other activities during the day with the use of repellent to people.
—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 m osquito.
pageoep15le ar puarEretEnicEducalaaernt rcisaku.sesevereillnessandpossibly deadtodeath
in any ag e group; however,

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

Please note the following within the context of a scho ol 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.4

Using RepellentsSafely

- *DEET* productsshouldnotbeusedoninfants under two months of age and should be used in concentrations of 30% or less onolderchildren.*Oiloflemoneucalyptus* should not be used on children under three years of age. *Permethrin*productsareintendedforuseon items such as clothing, shoes, bed nets and camping gear and should not be appliedtoskin.
- Follow theinstructionsontheproductlabel. If you have questions after reading the label, such as how many hours does theproductworkfor,orifandhowoften it should be reapplied, contact the manufacturer.
- Don't let children handle the product.
- To apply,putsomeonyourhandsfirstand then apply it to the child's arms, legs, neck and face.
- Don'tuserepellentsnearthemouthoreyes and use them sparingly around the ears.
- Be surenottoputanyrepellentonthechild's hands.
- Don'tapplyanyrepellantunderneaththechild's clothing or facemasks.
- Don'tuserepellentsonanycutsorirritated skin.
- Usejustenoughproducttolightlycoverexposed skin and/or clothing. Putting on a larger amount does not make
- the product work any better.
- If arashorothersymptomsdevelopandmay have been caused by using a repellent, stop using the product, wash theaffectedareawithsoapandwater,and contact a health care provider or local poison control center. If there is a visittothedoctor,sendtheproductwiththe child.

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

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 CAMPSFOR 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 IGETINFORMATION ONTHE 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 CAMPSREQUIREDTO PROVIDE COPIES OF OPERATING PLANS AND PROCEDURES?

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

ARETHEREMINIMUM QUALIFICATIONSFOR CAMPCOUNSELORS INMASSACHUSETTS?

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.

ISTHECAMPREQUIRED TO CONDUCT BACKGROUNDCHECKS ON CAMPSTAFF?

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 (CCrOimRiIn)aflf ender Record Information 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.

ISTHECAMP REQUIREDTOCHECK 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 THATSUCH 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.

ISTHECAMPREQUIRED TOHAVEA 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.

HOWCAN I COORDINATE MYCHILD'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 prescription

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praersticriippattioinng m eidni catoiofnf-,s ait ese coancdti voirtiis s guesIDns ad tbaeeIEnvat combine repellent with
container must be provided to the camp. The only his/her ommended, as over application of

DEET can occur if sunscreens need to be applied more frequently. It is generally recommended to apply

mindediviicdautaiol n isa ua tlhicoernizseedd hteoa lthg icvaer e puyrnosocufsercot,s tnhieland iln osre tcht erepellant. 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 HAVETO 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.

WHATSTEPSCAN BE TAKENTO 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

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

Revised March 2018

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:

Sawssioncei afltuea d isr espiratory disease 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/

- ExtremeHeat:

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 U/ O.Sp. erations Plans.
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

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Meningococcal Disease and Camp Attendees: Commonly Ask Question

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.

Youcan obtain more informationaboutmeningococcal disease orvaccination from yourhealthcare provider,your local Boardof Health (listed inthephone bookundergovernment), or theMassachusetts Departmentof PublicHealth 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

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 illnesse s aEnmd einrjgureinesc. y 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

AutomaticExternalDefibrillators (AEDs) and Epipens. Roxbury Latin has AEDs and EpiPens

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 mountedinthefoyer of the Smith Theater
5. In the Jarvis Refectorybuildingon the wall opposite the kitchen.
6. In the foyer of the GordonFieldHouse.
7. In the men's room ontheupperfields (during the Fall and Spring athletic seasons)
8. In the red backpack intheAthletic Training Room on the bottom shelf under the orange med kits or with the athletic traineratapractice or game
9. In the Indoor AthleticFacility(IAF) – west side, outside of the First Aid Room
10. In the IAF – east side,insideofthe Fitness Center

EpiPens. EpiPens containing epinephrinearestocked in the Athletic Trainer's office, the Nurse's Office, the Refectory and in the cabinet locatedintheErnest Wing. Also, campers with prescribed EpiPens are asked to carry their own EpiPen with thematalltimes. There are several campers who have a documented risk for anaphylactic reactionandwho have been prescribed an EpiPen. A list of these campers is kept by the Director's. Camperswho have a prescribed EpiPen andare suspected of havingananaphylactic reaction(explosivehives,swelling oflips, tongue, face, tightness throdifficulty breathing, nausea/stomach pain, confusion,senseof dread)should be given t EimpmiPediately. Immediately after giving the EpiPen, call 911 to activate the Emergency Medical System, call the camper's parents and have the camper transported to the emergency room.

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

Planfor InjuryPrevention andManagement

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 duringthe camp day are contacted by the Camp Director. Parents are also called if their child experiences a headbump, injury to the face, an injury or illness which may need further evaluation, or a situation where thechild 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 thereis 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

SUMMERCRISISRESPONSEPLAN

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 Nina	BTA Summer Camp Director – 617-283-9812
• 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.

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

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

- Camp Director will designate a camp representative to accompany the camper or campers to the hospital.
- Camper health record should be provided to the attending EMTs and hospital personnel

- In the event that alarger 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 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.

Camp Director checks Medical Log of campers that have been sent home for medical reasons.C heck to see if child left camp early.

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 mustleave 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.

II. All campers and staff who are in the Jarvis Refectory, Smith Art Center, and Bauer Science Building should proceed to the Smith Theater and gather in designated areas, by group level.

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.

V. Campers should remain quiet at all times.

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

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

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

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 through windows.

V. 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

TheMedia

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'spublic relations consultant and legal counsel, will prepare any necessary press releases. All informationreleased to the press will be consistent with that provided to the internal constituencies of the School.

The CMT will decide whether to allow themedia 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 mediaaccess. 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:

- A• ct 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

WoundCare / 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 systemicsymptoms of anaphylaxis/generalized urticaria/respiratory distress – follow EpiPen use protocol, call911 for immediate emergency medical care while providing supportive care.

Asthma / RespiratoryDistress

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.

105 CMR: 430.320 FOOD SERVICE

BTA Summer Sports Camps will not provide any campers with lunch or snacks each day. Campers will be responsible for bringing their own lunch and snack. Food should be placed in a cooler pack to ensure food is safe to eat. BTA staff will store packed lunches in coolers to maintain freshness.

.190 (B) CAMPER RELEASE

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

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
ExecutiveOffice ofHealthand HumanServices
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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Governor
KIMBERLEY DRISCOLL
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:
        - Use other staff to monitor pool decks on high heat/high volume days;
        - Ensurethere is enough disinfection and treatmentchemicals availableto maintaina safe and healthy pool during operation and after (for shocking procedures);
        - 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* • Texeellr tintghtem stop 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 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 103ºF) • Confusion • Dizziness • Red, hot, dry, or damp skin • Throbbing headache • Nausea • Losing consciousness (passing out) • Altered mental state Unconsciousness	• CALL911 – thisis a medical emergency • Reducetheperson's body temperaturewithwhatever means youcan-applycool wet towels or clothsontheperson, immerse them in acoolbath/shower, or spray them withcoolhosewater • Movethemtoacool place • Waituntilclearance from a medical professionalBEFORE you give themanythingtodrink • If thereisuncontrollable muscle twitching,keepthe person safe, but do notplaceanyobjects in their mouth • If thereisvomiting, turn the person on theirsidetokeep 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.