

RECREATIONAL CAMP LICENSE APPLICATION

Camp Name and Location Information		
Camp Name:		
Location where camp operates:		
City:	State:	ZIP Code:
Phone:	Fax:	
Email:		
Website/Social Media address:		
Camp Owner/Organization Information		
Owner/Organization Name:		
Primary Mailing address:		
City:	State:	ZIP Code:
Phone(year-round):	Fax:	
Email:		
<input type="checkbox"/> send license to this email address		
Camp Director/Operator Information (if different than owner)		
Director/Operator Name:		
Primary Mailing address:		
City:	State:	ZIP Code:
Phone(year-round):	Fax:	
Email:		
<input type="checkbox"/> send license to this email address		
Camp Operating Information		
If the camp previously operated in Massachusetts provide: year(s) the camp operated and the name(s) the camp operated under:		
<input type="checkbox"/> From: _____ To: _____		
Name(s): _____		
N/A		
Has the camp's license ever been suspended or revoked:(check): <input type="checkbox"/> Suspended <input type="checkbox"/> Revoked <input type="checkbox"/> Neither	Day or Residential Camp: <input type="checkbox"/> Day <input type="checkbox"/> Residential	
Seasonal or Year-Round Camp: <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-Round	Seasonal camp only: Opening Date for camp: _____ Closing Date for camp: _____ Hours of Operation: _____	
Swimming Pool(s): <input type="checkbox"/> Yes <input type="checkbox"/> Off-site <input type="checkbox"/> No	Pool Permit Number: _____ Off-Site Pools (if applicable): _____ Total Number of Pool(s): _____	
Bathing Beach(s): <input type="checkbox"/> Yes <input type="checkbox"/> Off-site <input type="checkbox"/> No	Names of lake or river located at camp (if applicable): _____ Off-Site beaches (if applicable) : _____	

Meals Provided: Yes No Food Permit Number: _____

Camp Capacity (per Session):
 Campers: _____ Staff: _____ Total Number for the Year: _____

Health Care Consultant Information

Name: _____

MA License Number: _____ Phone (to reach during camp operations): _____

Type of Medical License:

Physician Physician Assistant Other: _____
 Nurse Practitioner (NOTE: Attach documentation of pediatric training if a PA)

Health Care Supervisor Information

Name: _____

MA License Number: _____ Age: _____

Type of Medical License, Registration or Training 105 CMR 430.159(C):

Physician Physician Assistant Other: _____ Please attach
 Nurse Nurse Practitioner documentation of current First Aid / CPR Training

Aquatics Director Information

Name: _____ Age: _____

Lifeguard Certificate issued by: _____ Expiration date: _____	American Red Cross CPR Certificate: _____ Expiration date: _____
---	--

American First Aid Certificate: _____ Expiration date: _____	Previous aquatics supervisory experience: _____ _____ _____
--	--

Firearms Instructor Information

Name: _____

National Rifle Association Instructor's card (or equivalent): _____

Date Certified: _____ Expiration date: _____

Horseback Riding Instructor Information

Name: _____

License Number:	Expiration date:
Stable Location: _____	
Licensed in accordance with MGL c.111 §155, 158:	
<input type="checkbox"/>	<input type="checkbox"/>
Yes	No

Drinking Water and Plumbing Information

Is the camp a Public Water System (PWS) or connected to a town water supply?

<input type="checkbox"/>	PWS
<input type="checkbox"/>	Town water supply
<input type="checkbox"/>	Other: _____

Is the camp connected to a municipal sewer or other community, off-site sewage disposal system or is it served by on-site sewage disposal system(s)?

<input type="checkbox"/>	Municipal/Off-Site
<input type="checkbox"/>	On-Site (if on-site, Date of most recent septic tank pumping and inspection: _____)
<input type="checkbox"/>	Other: _____

Renewal or Previously Submitted Information

If **ALL** of the above information was previously submitted **and** has not changed, please note:

INFORMATION ON FILE from previous years

Certification and Signature

I authorize the verification of the information provided in and with the application is true, complete, and not misleading to the knowledge and belief of the signer. I understand that any license granted based on false, incomplete, or misleading information shall be subject to suspension or revocation.

Signature of applicant:	Title:
Name (Please Print):	Date:

Comments or Additional Information

Required Documentation:

Please consult 105 CMR 430.000, MA Regulations for Minimum Standards for Recreational Camps for Children, State Sanitary Code, Chapter IV and all guidance documents, prior to filling out the application. Additionally, contact the Department of Public Health, Bureau of Environmental Health, Community Sanitation Program for any questions regarding the following documents:

- Staff information forms (e.g. - applications, contact information, health records, certifications, etc.)
- Procedures for the background review of staff and volunteers [105 CMR 430.090]
- A copy of promotional literature [105 CMR 430.190(C)]
- Procedures for reporting suspected child abuse or neglect [105 CMR 430.093]
- A camp health care policy [105 CMR 430.159(B)]
- A discipline policy [105 CMR 430.191]
- A fire evacuation plan – approved by the local fire department [105 CMR 430.210(A)]
- A written statement of compliance from the local fire department [105 CMR 430.215]
- A Disaster/Emergency plan [105 CMR 430.210(B)]
- A lost camper plan [105 CMR 430.210(C)]
- A lost swimmer plan (when applicable) [105 CMR 430.210(C)]
- A traffic control plan [105 CMR 430.210(D)]
- For Day Camps – contingency plans [105 CMR 430.211]
- **For Field Trips** – A written itinerary, including sources of emergency care, access to health records/medication/first aid kits and contingency plans to be provided to the parents/guardians prior to departure [105 CMR 430.212]
- A current certificate of inspection from the local building inspector [105 CMR 430.451]
- If applying for an initial license after January 1, 2000 – the lab analysis of a private well water supply source (if applicable) [105 CMR 430.300,.303]

Please note:

When seeking a recreational camp license for each community where the camp is located, an applicant shall file an application with the Board of Health at least 90 days prior to the desired opening date, using a form provided by the Department or available from the Board of Health documenting all required information, including, but not limited to, a plan showing the buildings, structures, fixtures and facilities, as needed. [105 CMR 430.631]