



Maryland  
DEPARTMENT OF HEALTH

# Youth Camp Regulation Training 2025

**Prevention and Health Promotion Administration**

**Center for Recreation and and Community Environmental Health Services**

**6 St Paul Street, Suite 1301**

**Baltimore, MD 2120**

**[health.maryland.gov/youth-camps](https://health.maryland.gov/youth-camps)**

**Phone 410-767-8417**

**Fax 410-333-8926**



## **MISSION AND VISION**

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### **MISSION**

The mission of the Prevention and Health Promotion Administration is to protect, promote and improve

the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving

special attention to at-risk and vulnerable populations.

### **VISION**

The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

## CRCEHS Staff

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Baltimore, Baltimore City, Calvert, St. Mary's,  
Washington

# Training Outline

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1. What is a Youth Camp
2. Background Checks
3. Plans & Procedures
4. Facilities
5. Health Program
6. Application Process
7. Inspection & Fees
8. Required Reports

— *Section 1*

## What is a Youth Camp

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- Regulations
- Day Camp
- Residential Camp
- What is not a camp

## Legal Authority/Regulation

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### **Law**

Youth Camp Act: Health General Title 14 Subtitle 4

### **Regulations**

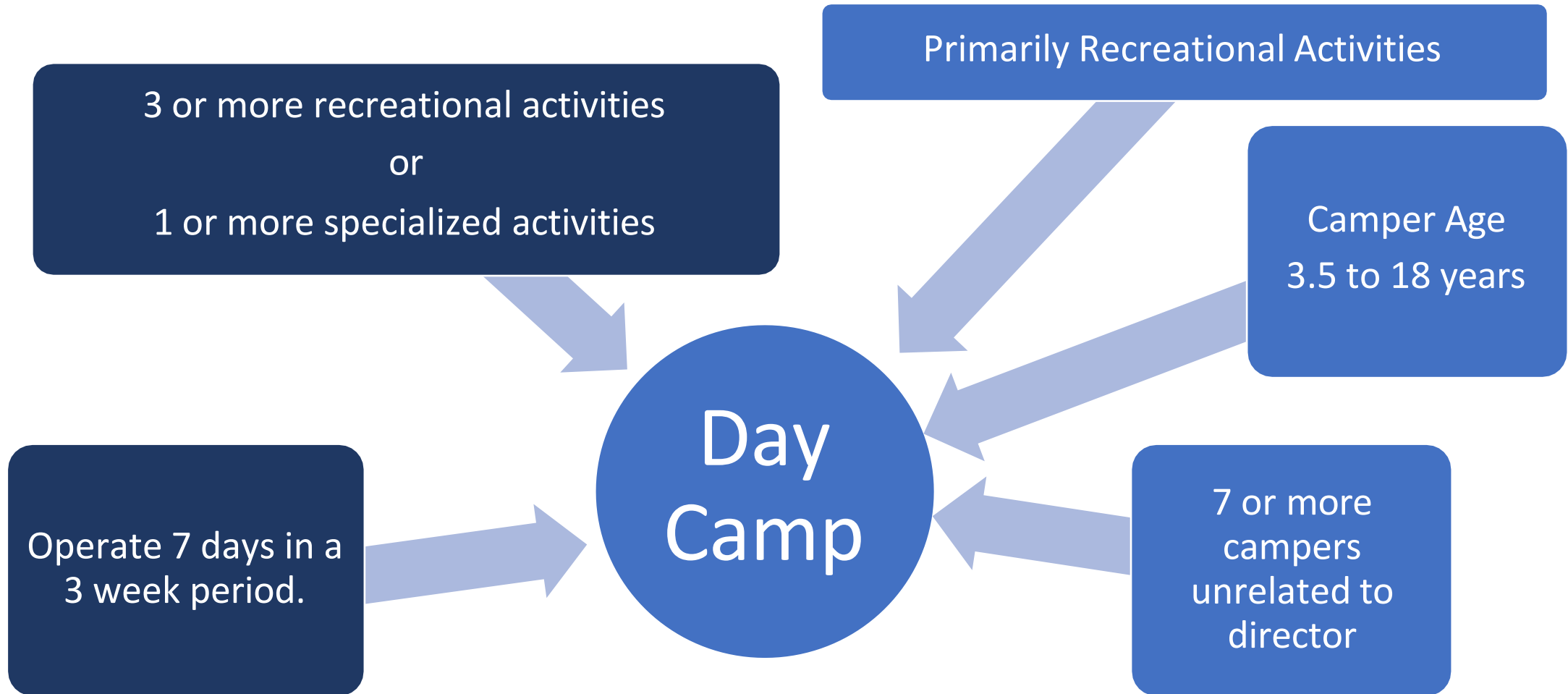
- Certification for Youth Camps
  - COMAR 10.16.06
- Health and Medication Requirements for Youth Camps
  - COMAR 10.16.07
- Fee Schedule
  - COMAR 10.01.17

*Is My Program a “Youth Camp”?*

## Day Camp

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COMAR 10.16.06.02B(13)

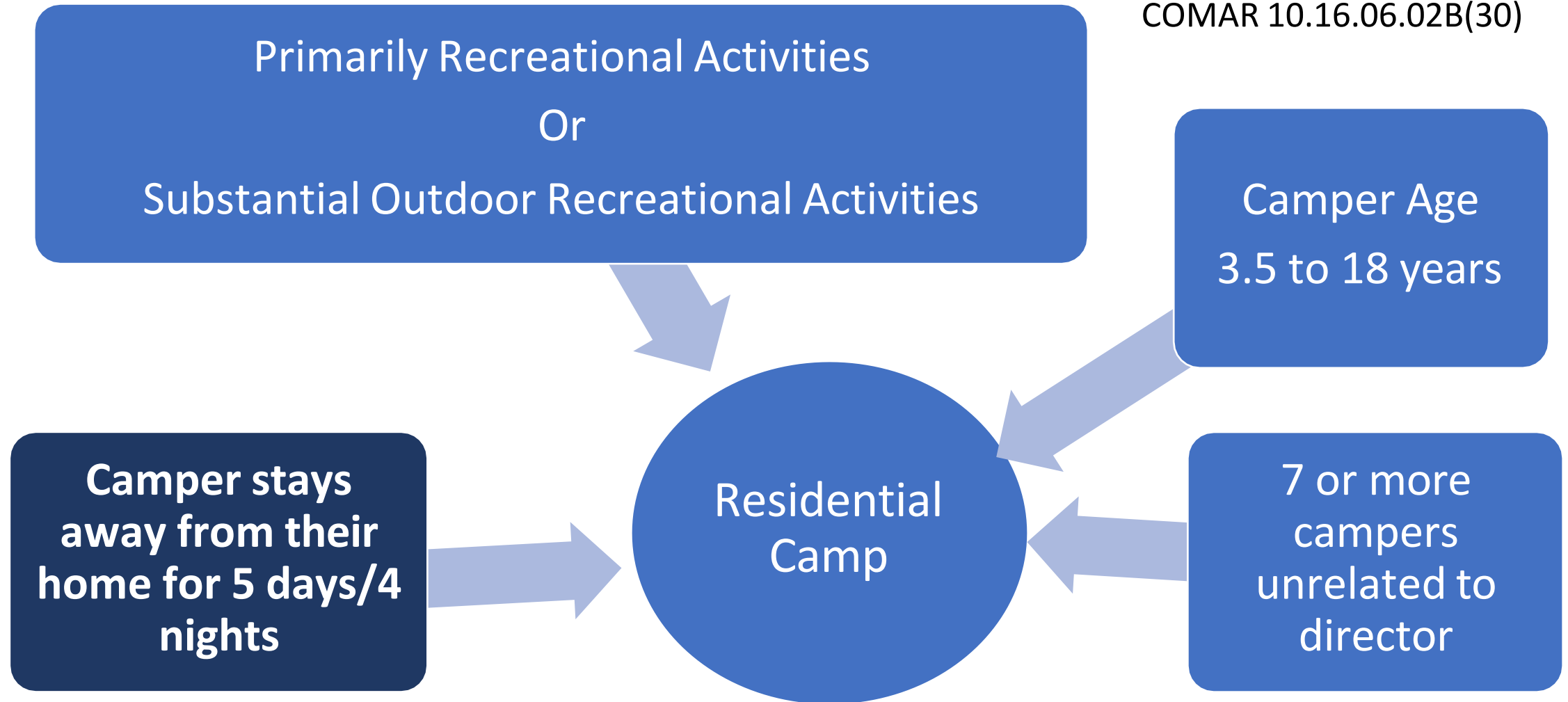


*Is My Program a “Youth Camp”?*

## Residential Camp

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COMAR 10.16.06.02B(30)



*Is My Program a “Youth Camp”?*

## What Is NOT a Youth Camp?

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COMAR 10.16.06.02B(39)(c)

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- An instructional program of 2 hrs. or less in a specialized activity

*Is My Program a “Youth Camp”?*

## What Is NOT a Youth Camp?

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COMAR 10.16.06.02B(39)(c)

- A summer school program taught by certified teacher and offering credit
- A program or activity where parents/guardians are present for duration, participate, and oversee activities of the child

## What Is NOT a Youth Camp?

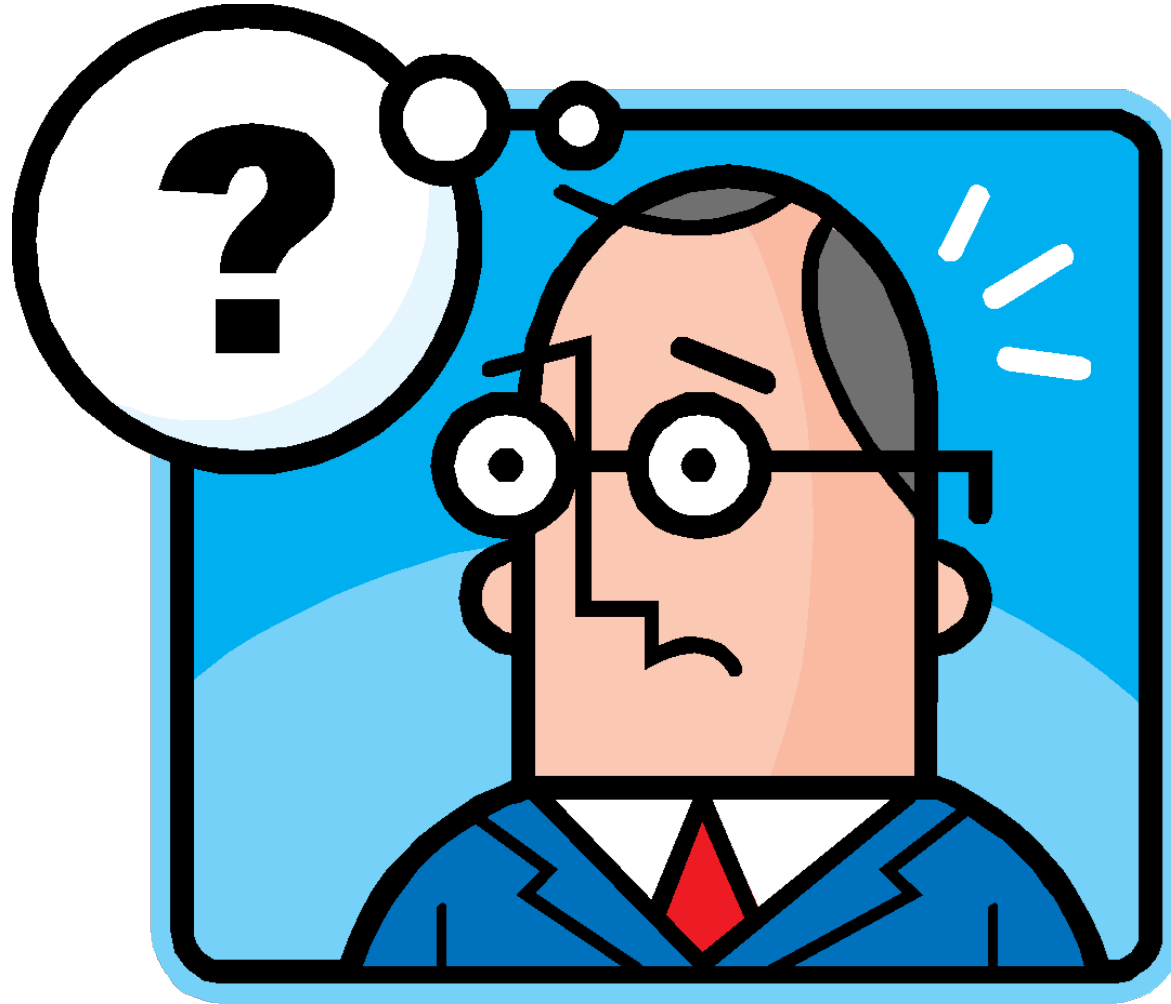
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COMAR 10.16.06.02B(39)(c)

- A program enrolling children under the age of 3.5 years old cannot be licensed as a youth camp.  
(The operator should consult with Child Care Administration to see if a child care license is required)

# Questions?

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*Background Checks and Clearances*

COMAR 10.16.06.21

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© Viviane Moos



# Required Background History Check

## Three Required Components:

- Fingerprint Supported Criminal Background Check Through CJIS MD
- Fingerprint Supported Criminal Background Check Through CJIS FBI
- Child Abuse and Neglect Database Check in the State of Maryland Through Child Protective Services



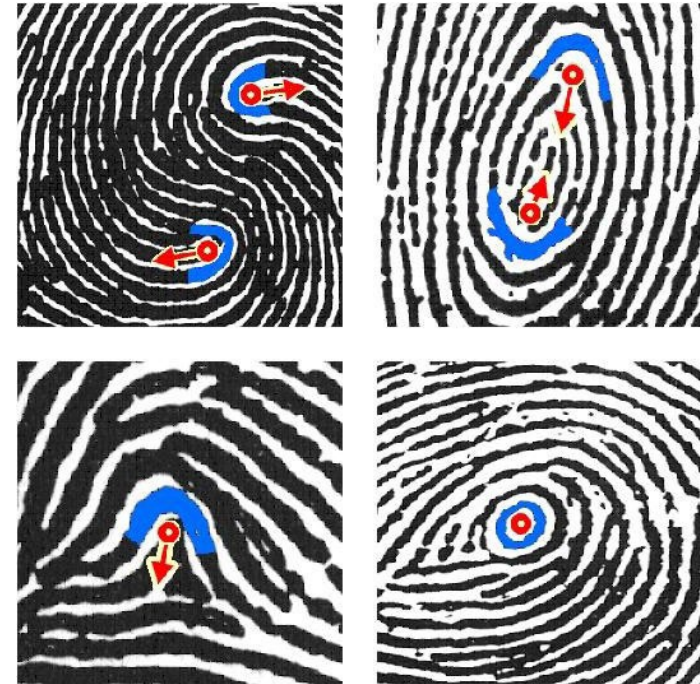
## COMAR 10.16.06.21

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### **Who is required to complete a background history check at camp?**

- All paid employees
- All volunteers

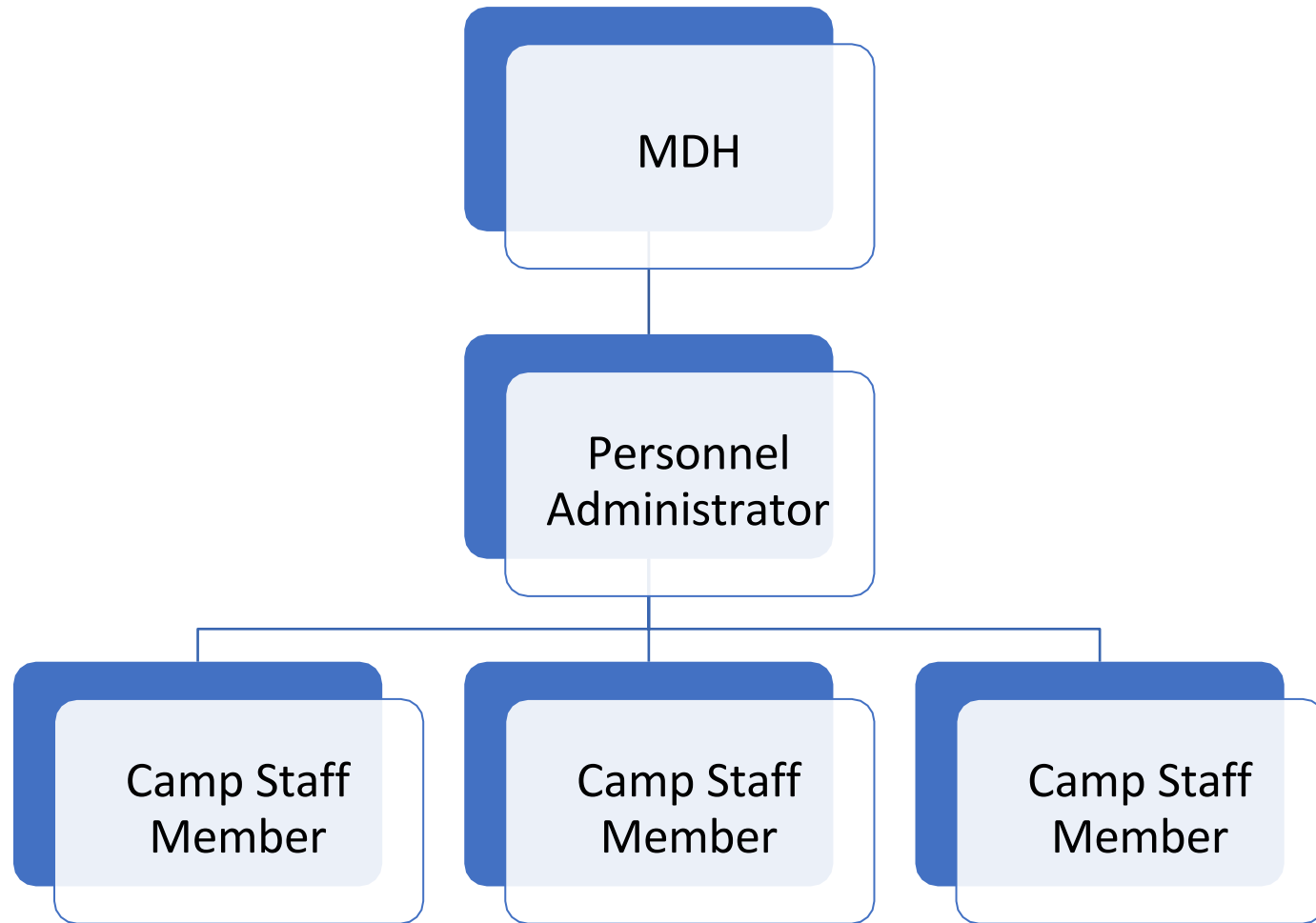
\*This includes minor employees and volunteers under the age of 18\*



*Background Checks and Clearances*

COMAR 10.16.06.21

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## Personnel Administrator

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### CJIS

- Use MDH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***

### CPS

- Send MDH a copy of the signed and notarized CPS consent form  
(NOT TO DHS)

Background Checks and Clearances

# CJIS Authorization Number

- Camp applies for Authorization Number through **CJIS**
- Results are sent to contact person
- Email notification
- View/print results from secure web site (TIME SENSITIVE)

The screenshot shows a form titled "APPLICATION TO RECEIVE CRIMINAL HISTORY RECORD INFORMATION FOR EMPLOYMENT OR LICENSING PURPOSES". At the top left is the State of Maryland seal. To its right is the text: "STATE OF MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES INFORMATION TECHNOLOGY AND COMMUNICATIONS DIVISION CRIMINAL JUSTICE INFORMATION SYSTEM - CENTRAL REPOSITORY (CJIS-CR)".

**PART I. AGENCY CONTACT INFORMATION**

Name of Agency: \_\_\_\_\_

Agency Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Agency Point of Contact: \_\_\_\_\_

Agency Point of Contact's Position/Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Is your agency a governmental agency?  Yes (please complete Part III ONLY)  No (please complete Parts II and III)

**PART II. GOVERNMENTAL AGENCY CONTACT INFORMATION**  
If you answered 'Yes' in Part I, please provide the name of the contact person from the governmental agency that has employment/licensing authority over your agency.

List the statutory (legal) authority that authorizes your agency to receive federal criminal history information:  
(ex. Criminal Procedure Article, §10-236.3, Annotated Code of Maryland) \_\_\_\_\_

Governmental Agency Name: \_\_\_\_\_

Governmental Agency Point of Contact: \_\_\_\_\_

Governmental Agency Primary Point of Contact's Position / Title: \_\_\_\_\_

Maryland and FBI CJIS

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- All required employees
- “Employee or Volunteer” that has access to the campers
- Copy of results must be addressed to employer, not the employee

# Background Checks and Clearances

## Fingerprints



STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
INFORMATION TECHNOLOGY AND COMMUNICATIONS DIVISION  
CRIMINAL JUSTICE INFORMATION SYSTEM - CENTRAL REPOSITORY (CJIS-CR)

### LIVESCAN PRE-REGISTRATION APPLICATION

**APPLICANT INFORMATION**  
Please type or print legibly.

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender:  Male  Female  
Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs. Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
Race/Ethnicity:  Black  White  Asian/Pacific Islander  Native American  Other  
Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**REASON FOR REQUEST**  
**INDIVIDUAL**

Please select one of the following:

- Gold Seal/Adoption (Enter Authorization Number if applicable)
- Gold Seal/Letter/VISA
- Immigration/VISA
- Individual Challenge
- Individual Review
- Attorney/Client (Written Authorization Required)

**Mailing Information:**  
Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**AGENCY**

Please select from the following (\*ORI Required):

- Adult Dependent Care
- Child Care\*
- Criminal Justice\*
- Government Employment\*
- Government Licensing or Certification\*
- Maryland State Police Licensing\*
- Private Party Petition\*\*
- Public Housing

Agency Authorization Number: \_\_\_\_\_  
\*ORI Number: MD920523Z  
\*\*Position Applied: \_\_\_\_\_

**APPLICANT**

STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
INFORMATION TECHNOLOGY AND COMMUNICATIONS DIVISION  
CRIMINAL JUSTICE INFORMATION SYSTEM - CENTRAL REPOSITORY (CJIS-CR)

08 3038 03184 5

APPLICATION FOR CRIMINAL HISTORY RECORD CHECK

READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION  
ONLY ORIGINAL APPLICATION WILL BE PROCESSED  
TYPE OR PRINT ALL INFORMATION CLEARLY  
CHECK OR MONEY ORDER (NO CASH) MADE PAYABLE TO:  
CJIS CENTRAL REPOSITORY  
MAIL COMPLETED APPLICATION TO:  
CJIS, P.O. BOX 32700, Pikesville, MD 21288-2708  
OR RETURN TO REQUESTING AGENCY  
FOR ASSISTANCE CALL 410-784-4501

State Only  
 State and FBI  
 State and FBI Volunteer  
CJIS REQUEST TYPE:  
 Check Only One  
 Adult Dependent Care  
 Attorney/Client  
 Criminal Case #  
 Child Care  
 Criminal Justice  
 Gold Seal Letter/Adoption  
 Gold Seal Letter/Visa  
 Government Employment  
 Government  
 Licensing or Certification  
 Immigration/Visa  
 Individual Challenge  
 Individual Review  
 MSP Licensing  
 Private Employer Position  
 Public Housing Authority  
 Payment Enrolled  
Amount \$ \_\_\_\_\_  
Check or M.O. # \_\_\_\_\_  
 Bill Authorization Account  
(must have approved billing agreement)  
 Indigent (Form must be attached with verification)  
 One FBI fingerprint card enclosed for FBI

**Maryland CJIS no longer accepts inked fingerprints as of April 15, 2012, except for out of state. Use LIVESCAN PRE-REGISTRATION APPLICATION**

# Background Checks and Clearances

# ORI NUMBER

## USE THE CORRECT ORI NUMBER



STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
INFORMATION TECHNOLOGY AND COMMUNICATIONS DIVISION  
CRIMINAL JUSTICE INFORMATION SYSTEM - CENTRAL REPOSITORY (CJIS-CR)

### LIVESCAN PRE-REGISTRATION APPLICATION

#### APPLICANT INFORMATION

Please type or print legibly.

|   |                          |   |             |
|---|--------------------------|---|-------------|
| Name:   |                          |   |             |
| Date of Birth:  | Social Security Number:  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |             |
| Height: ft. in.   | Weight: lbs.             | Eye Color:  | Hair Color: |
| Race/Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other |                          |   |             |
| Place of Birth:   |                          | Citizenship:  |             |
| Street Address:   |                          |   |             |
| City:   |                          | State:  | Zip Code:   |
| Phone Number:   | Driver's License Number: | Email Address:  |             |

#### REASON FOR REQUEST

##### INDIVIDUAL

Please select one of the following:

- Gold Seal/Adoption (Enter Authorization Number if applicable) \_\_\_\_\_
- Gold Seal/Letter/VISA
- Immigration/VISA
- Individual Challenge
- Individual Review
- Attorney/Client (Written Authorization Required)

**Mailing Information:**

|                 |  |        |           |
|-----------------|--|--------|-----------|
| Name:           |  |        |           |
| Street Address: |  |        |           |
| City:           |  | State: | Zip Code: |

##### AGENCY

Please select from the following (\*ORI Required):

|   |   |   |
|---|---|---|
| <input type="checkbox"/> Adult Dependent Care   | <input type="checkbox"/> Government Employment*                 | <input type="checkbox"/> Private Party Petition** |
| <input checked="" type="checkbox"/> Child Care* | <input type="checkbox"/> Government Licensing or Certification* | <input type="checkbox"/> Public Housing           |
| <input type="checkbox"/> Criminal Justice*      | <input type="checkbox"/> Maryland State Police Licensing*       |   |

Agency Authorization Number: \_\_\_\_\_

\*ORI Number: MD920523Z

\*\*Position Applied: \_\_\_\_\_

# Background Checks and Clearances

## CJIS Results

State of Maryland  
Department of Public Safety and Correctional Services



G. Lawrence Franklin  
Deputy Secretary  
Ronald C. Brothers  
Chief Info. Officer  
C. Kevin Combs  
Deputy Chief Info. Officer  
Carole Shelton  
Director

Martin O'Malley  
Governor  
Anthony G. Brown  
Lt. Governor  
Gary D. Maynard  
Secretary

**Information Technology and Communications Division**  
Criminal Justice Information System - Central Repository  
Post Office Box 32708 - Pikesville, Maryland - 21282-2708  
Main No: 410-764-4501 - Toll Free: 1-888-795-0011  
www.dpacs.state.md.us

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS  
LINDA RUDIE  
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES  
BALTIMORE, MD 212021608

Received: 02/02/2011  
Reference: 1 [REDACTED]

February 02, 2011

Your request for a criminal history record check of Maryland's Criminal Justice Information System has been completed. This record check was based upon the identification information provided as follows:

NAME: [REDACTED]  
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

- No criminal history was found under the Maryland statute or regulation authorizing you to receive the information.
- A fingerprint supported national criminal history record check has been initiated. The results of that investigation will be sent to the requesting agency only.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and may not contain data prior to 1978.

*Carole Shelton*

Carole Shelton, Director  
Criminal Justice Information Systems  
Central Repository

February 02, 2011 - 1 [REDACTED] - R\_CJIS

Fax: 410-653-8326

State of Maryland  
Department of Public Safety and Correctional Services



G. Lawrence Franklin  
Deputy Secretary  
Ronald C. Brothers  
Chief Info. Officer  
C. Kevin Combs  
Deputy Chief Info. Officer  
Carole Shelton  
Director

Martin O'Malley  
Governor  
Anthony G. Brown  
Lt. Governor  
Gary D. Maynard  
Secretary

**Information Technology and Communications Division**  
Criminal Justice Information System - Central Repository  
Post Office Box 32708 - Pikesville, Maryland - 21282-2708  
Main No: 410-764-4501 - Toll Free: 1-888-795-0011  
www.dpacs.state.md.us

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS  
LINDA RUDIE  
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES  
BALTIMORE, MD 212021608

Received: 02/02/2011  
Reference: 1 [REDACTED]

Originally printed: 2011-02-02

February 02, 2011

Your request for a criminal history record check has been conducted. Information from the Federal Bureau of Investigation (FBI), based upon the fingerprint supported identification information indicated below, has been reviewed.

Name: [REDACTED]  
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

- The FBI criminal history investigation has been completed. The covered individual is not the subject of any criminal charge/charges.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and does not contain data prior to 1978.

*Carole Shelton*


Carole Shelton, Director  
Criminal Justice Information Systems  
Central Repository

February 02, 2011 - 1 [REDACTED] - R\_FBI

Fax: 410-653-8326

# Background Checks and Clearances

## 365 Day Request



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

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

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

ADDRESS \_\_\_\_\_  
(Number) (Street) (P.O. Box)

\_\_\_\_\_  
(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

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

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

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

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

.....

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

\_\_\_\_\_  
(EMPLOYER NAME)

\_\_\_\_\_  
(ADDRESS)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

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

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

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

.....

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

.....

**FOR CJIS CENTRAL REPOSITORY USE ONLY**

This request can not be processed because:

\_\_\_\_\_ this is not a valid reference number

\_\_\_\_\_ this is not a valid authorization number

\_\_\_\_\_ this reference number has not been received at the Central Repository

\_\_\_\_\_ this authorization number is not approved for this request.

\_\_\_\_\_ the application associated with this reference number was received more than 365 days before receipt of this request.

\_\_\_\_\_ requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge



## CPS Background Clearance

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- All required employees
- “Employee or Volunteer” that has access to the campers

## CPS Background Clearance

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- All employees and volunteers must complete Child Protective Services (CPS) background clearance through myDHR portal (myMDThink/myDHRbenefits)

CONSENT FOR RELEASE OF INFORMATION

CPS BACKGROUND / ADAM WALSH BACKGROUND CLEARANCE REQUEST

- Personnel Administrator keeps original signed and notarized form on file at camp.
- Personnel Administrator must “Submit” and Complete online via myDHR site.
- CPS Background Clearance result is received via email from myDHR site or can be viewed on the site.

## Reviewing Results

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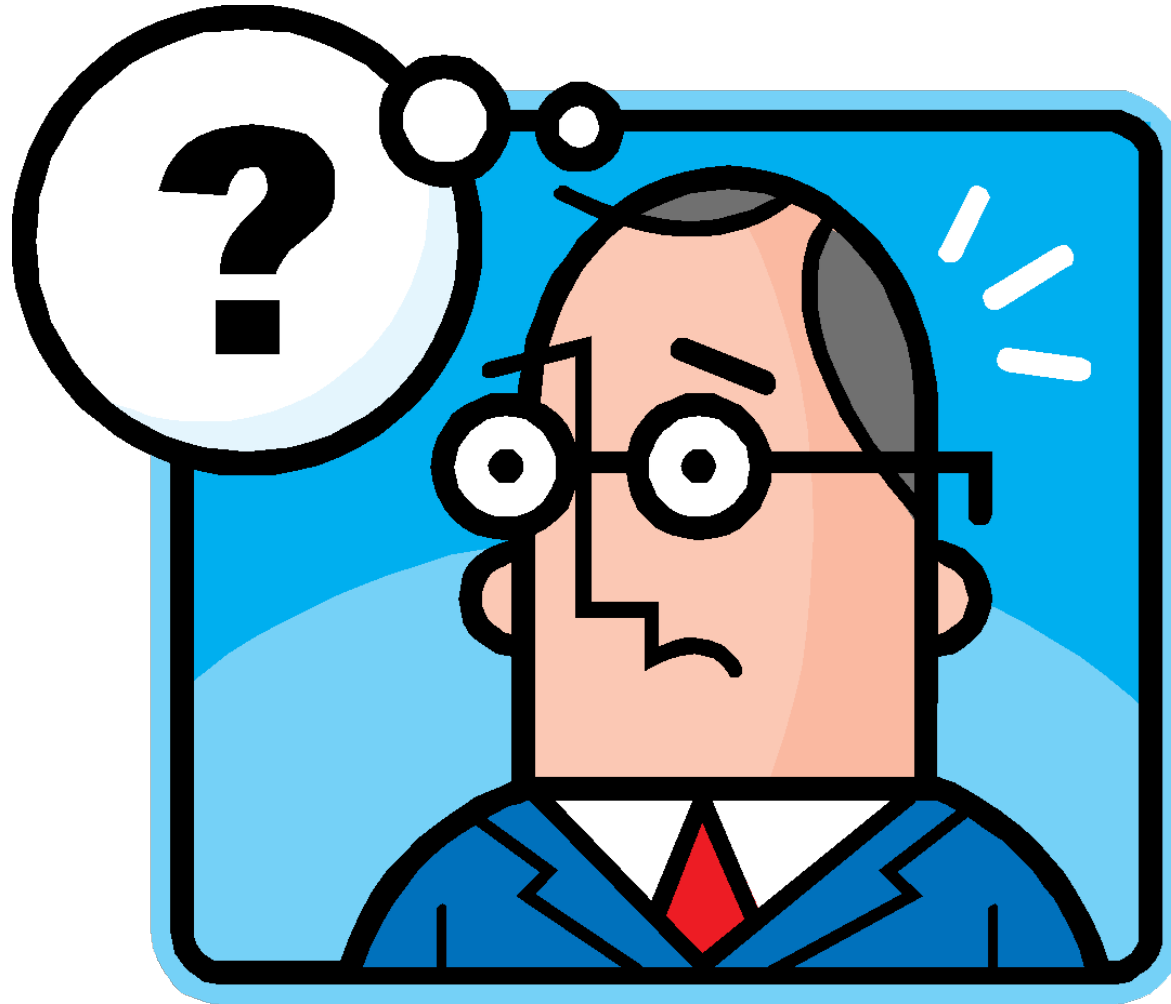
COMAR 10.16.06.21

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- Cannot employ an individual with a conviction, probation before judgment, not criminally responsible disposition or pending charge listed in Regulation .21E.
- Per Regulation .21F, if results indicate that the individual is responsible for child abuse/neglect or includes a crime not included in .21E, then Personnel Administrator must assess hiring based on job position, nature/seriousness of the crime, how long ago, individual's age, probation/parole and other pertinent information.

*Background Checks and Clearances*

Questions?

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## 5 Minute Break

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**05:00**

- *Section 3*  
Procedures

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Emergency

Trip & Transportation

Specialized Activities

Child Abuse Prevention and Reporting

Supervision

# Procedures

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## Emergency Procedures

- Regulation 10.16.06.34

## Trip and Transportation

- Regulations 10.16.06.52 and .53

## Supervision during routine activities

- Regulation 10.16.06.54

## Specialized Activities

- Regulations 10.16.06.47 through .52

## Child Abuse Prevention and Reporting

- Regulation 10.16.06.35

# Emergency Procedures

## Regulation 10.16.06.34

- (1) Ensure camper safety during natural disasters, severe weather, and other emergencies;
- (2) Evacuate campers from the camp;
- (3) Account for campers and locate a missing camper;
- (4) Use fire, rescue, police, and 911 services;
- (5) Ensure emergency transportation;
- (6) Notify the camper's parent or guardian;
- (7) Ensure camper safety until the camper's parent, guardian, or parent's or guardian's designee picks up the camper;
- (8) Monitor for adverse weather conditions/air quality





# Emergency Procedures

## Missing Campers?

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6 ?

- Head count
- Missing campers
- Finding missing campers

## Ensure Camper Safety

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Maintain the safety of the other campers while searching for a missing camper.



## Notify Parents

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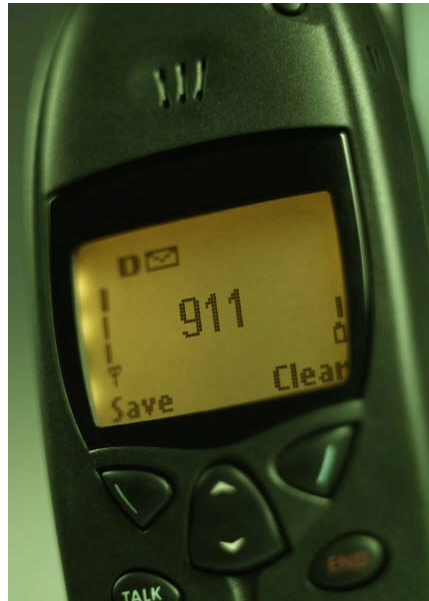
Mechanisms for notifying parents of changes to pick-up or drop-off locations due to an emergency situation



# 911

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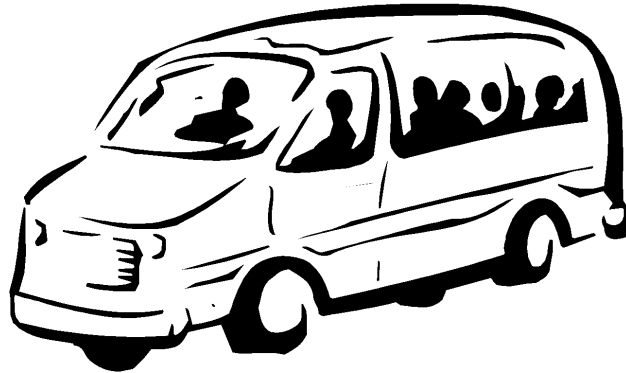
Does camp use cell phones or another communication plan?  
Who is responsible for calling 9-1-1?



## Transportation for Evacuation

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Emergency transportation plan for evacuating the entire facility.



## *Specialized Activities*

### Regulation 10.16.06.47 - .52

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- All Specialized Activities
  - Director Present
  - Safety Plan Developed and Implemented
  - Staff Training
  - Staff Ratio (1 staff to 10 campers)
- Swimming
  - Swim ability test
  - Safety system to quickly account for campers
  - WATCHERS, WATCHERS, WATCHERS (16 or over every 25)
- Marksmanship
- Horseback Riding (ASTM) F1163;

## Watchers What are they?

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- A “Watcher” is a designated individual who provides **constant vigilance and , undistracted** supervision of Campers in water. ensuring their safety and preventing potential drowning incident

### **who Should be a Watcher?**

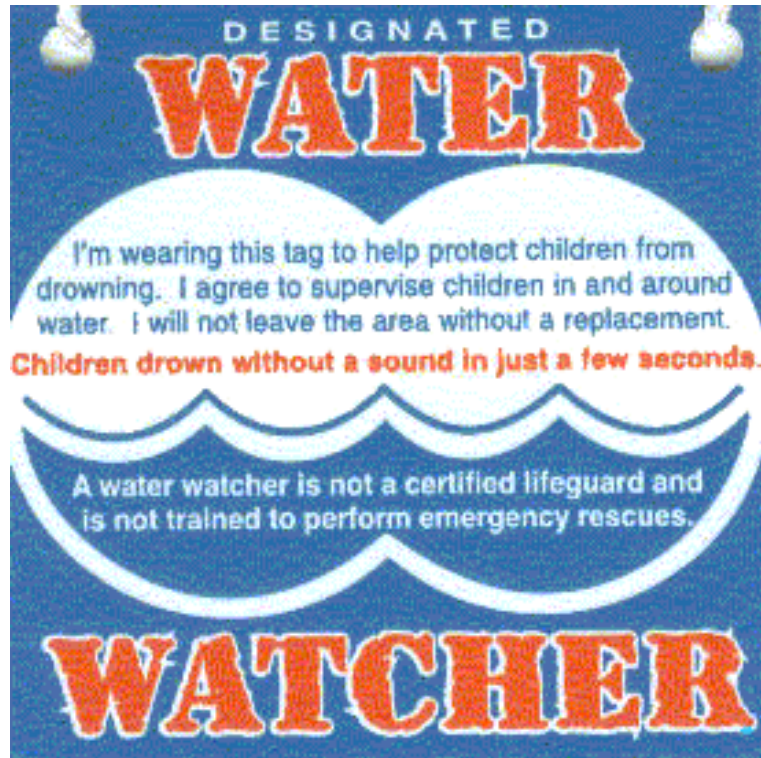
- They should have the skills,knowledge, and ability to recognize someone in distress and alert the lifeguard for rescue.
- Should have access to a working phone to call emergency help (911)
- Should know CPR or be able to immediately alert someone nearby who can.

*Specialized Activities*

# Watchers Tag examples

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: IPSSA [waterwatcher.org](http://waterwatcher.org) and Safe Kids World



*Specialized Activities*

# Swimming

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X - Location of watchers

G - Gather location



## *Specialized Activities*

# Natural swimming Beaches Safety

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- Check with your local health department or MDE before swimming in natural waters.
- Avoid swimming within 48 hours of a heavy rain event.
- Do not swim near storm drains located along the beach area.
- Do not swim near if the water looks cloudier than usual, is discolored, or smells bad.
- Do not swim if you see any pipes draining into or around the water
- Try not to swallow beach water.
- Avoid swimming if you feel ill or have open cuts or sores. If water contact can't be avoided, cover your open cut or sore with waterproof bandages.
- Always take a shower or bathe after swimming.
- If they are available use diaper-changing stations in restroom facilities, or change diapers away from the waters' edge.
- Remember to properly dispose of used diapers.
- Wash your hands with soap and warm water after using the bathroom or changing diapers.
- Pick up waste from your pets and dispose of it in the trash.
- Get involved and volunteer in local beach clean up efforts.
- Do your part and encourage others to keep picnic areas near the beach free of debris and garbage.
- Do not attract duck, geese, or seagulls by feeding them.
- When boating, use an approved marina pump-out station for boat waste disposal.
- If you have a septic tank system, keep it maintained and in good working order.
- 43 If you see any unsafe or unhealthy conditions, report them to a lifeguard or beach manager.

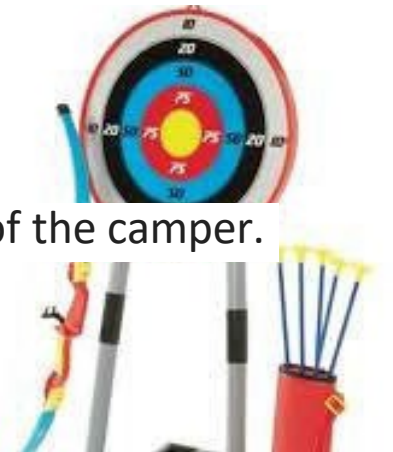
## *Specialized Activities*

# Archery

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A. Archery Range. For a camp that offers archery activities, an operator shall ensure that:

- (1) An archery range is located where a camper will not wander into the danger area while engaged in other camp activities;
- (2) An archery range is clearly marked to warn individuals away from the danger area;
- (3) When possible, the shooting direction is to the north to minimize an archer being blinded by the sun;
- (4) The shooting area has at least 50 yards of clearance or an archery net behind each target; and
- (5) When different archer-to-target distances are required for a group that is shooting at the same time on the same field:
  - (a) One common shooting line is used; and
  - (b) The targets are set at a distance from the shooting line that is appropriate with the skill level of the camper.



## *Specialized Activities*

# Archery

---



B. An operator shall ensure that:

- (1) Archers fire from a common firing line with a ready line marked behind it;
- (2) Only an archer ready to shoot is on the firing line and anyone waiting to shoot remains behind the ready line;
- (3) An individual stays behind the firing line at all times except when ordered by the instructor to retrieve a target or an arrow; and
- (4) Bows and arrows are stored in a locked enclosure.

C. Staff Members. For a camp that offers archery activities, an operator shall ensure that:

- (1) During the archery activity, a director is present at the camp or, when the activity occurs off the camp premises, the activity site;
- (2) An instructor and at least one counselor or assistant counselor to assist are on the range at all times during a firing session; and
- (3) One adult staff member, adult volunteer, counselor, or assistant counselor is on duty and supervising the campers for each group of ten campers or fraction of ten campers on the firing line.

D. Procedures. An operator shall ensure that a safety plan is developed and implemented:

## *Child Abuse Prevention and Reporting*

# Regulation 10.16.06.35

---

- A. Child abuse allegations or incidents are reported as prescribed in Family Law Article, §§5-704 and 5-705, Annotated Code of Maryland;
- B. A written child abuse prevention and reporting program is prepared and implemented at the camp that includes procedures for:
- (1) Educating staff members and volunteers;
  - (2) Reporting child abuse both internally and externally;
  - (3) Screening staff members and volunteers prior to working at camp;
  - (4) Reinforcing the camp's policies and procedures during camp operation;
  - (5) Evaluating the facilities and grounds;
  - (6) Supervising campers;
  - (7) Educating on appropriate touching;
  - (8) Responding to inappropriate behaviors by staff, volunteers, parents, and campers;
  - (9) Communicating with staff members, volunteers, parents, the Department, and the media;
  - (10) Supporting an alleged victim; and
  - (11) Interacting with an alleged perpetrator



## Staff Training

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From Baltimore Child Abuse Center

Review video at

<https://www.bcaci.org/pages/training-education-outreach-offerings/>

**Understanding Your Responsibilities as a Mandated Reporter:**

**Summer Camp Training:**

**Child Sexual Abuse Prevention Training:**

**Internet Safety for Parents and the Community:**

## Regulation 10.16.06.52 and .53

---

- Written Safety Plans for:
  - Field trips (On line)
  - Transportation (On Line)
    - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision

## *Trip and Transportation*

### Regulation 10.16.06.52 and .53

---

A. When a camper, staff member, or volunteer is transported, an operator shall ensure that:

(1) Transportation is provided according to applicable State law;

(2) A transportation safety plan is developed and implemented that includes:

(a) Transportation safety rules, standards, and practices;

(b) Supervision requirements including camper to staff ratios;

(c) Emergency transportation services; and

(d) Severe weather procedures;



*Supervision*

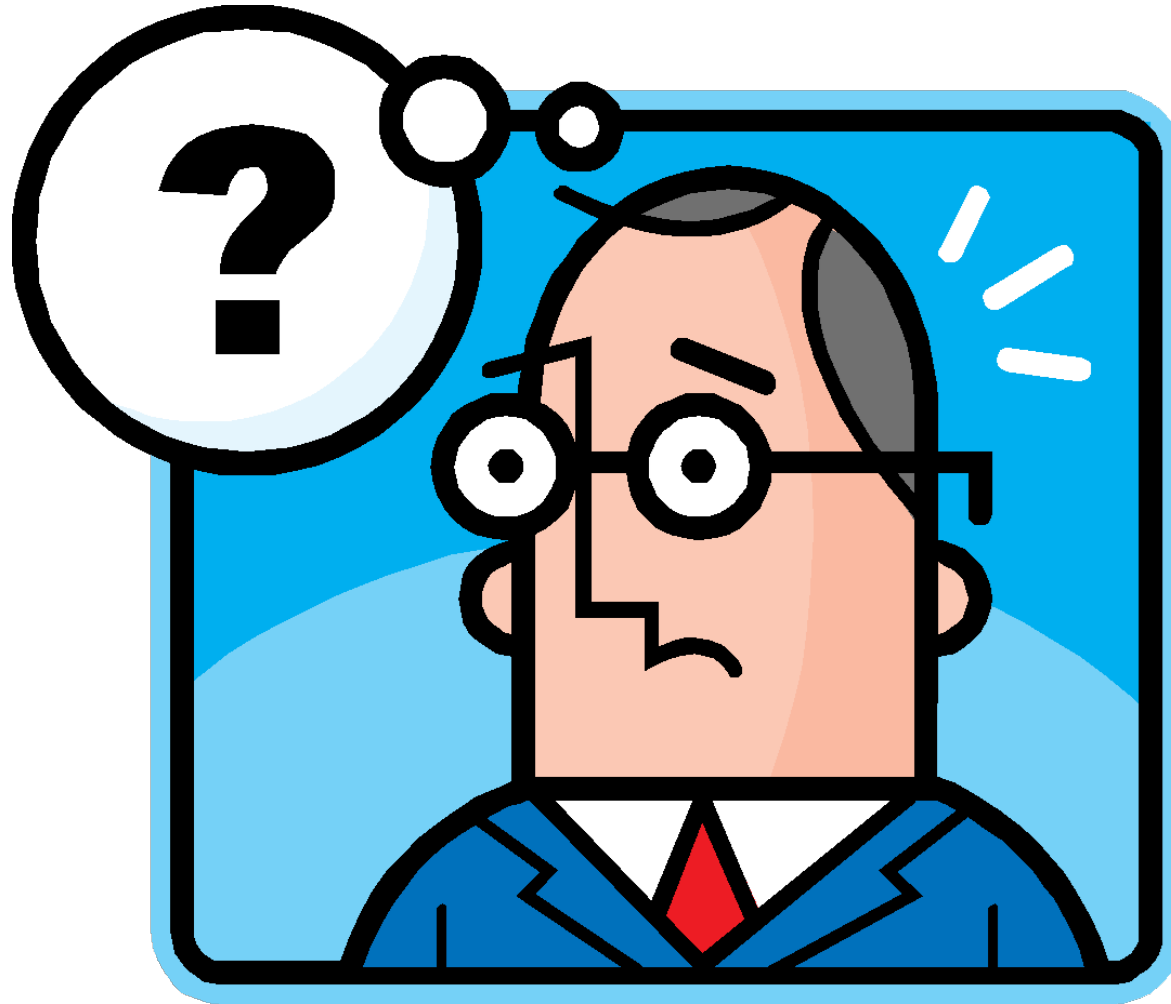
# Regulation 10.16.06.54

| Campers               | Required Number of Adults and Assistant Counselors |                                |
|-----------------------|--|--------------------------------|
|                       | Adults   | Assistant Counselors or Adults |
| 3 ½ to 5 years old    |  |                                |
| 1 to 8                | 1  | 0                              |
| 9 to 16               | 1  | 1                              |
| 17 to 24              | 1  | 2                              |
| 6 to 10 years old     |  |                                |
| 1 to 15               | 1  | 0                              |
| 16 to 30              | 1  | 2                              |
|                       | Or 2   | 0                              |
| 11 years old or older |  |                                |
| 1 to 15               | 1  | 0                              |
| 16 to 30              | 1  | 2                              |
|                       | Or 2   | 0                              |
| 31 to 40              | 2  | 2                              |
|                       | Or 3   | 0                              |

*Procedures*

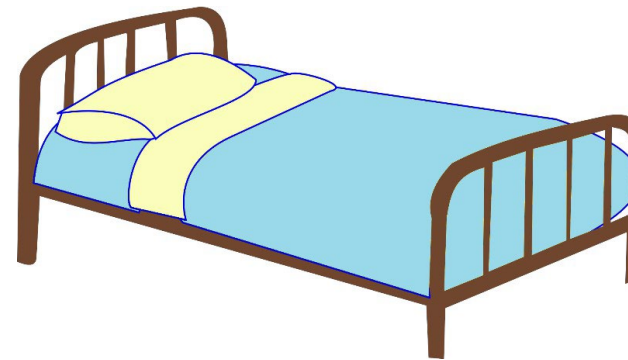
Questions?

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*Facilities*

# Construction & Building Documentation



## Documentation for Private Building

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- Building COMAR 10.16.06.46
  - Use and Occupancy Permit, or
  - Zoning Approval & Master Plumber and Master Electrician Letters
- Water and Sewage
  - Public Water and Sewer, or COMAR 10.16.06.36
  - Local Health Approval Form (annual) COMAR 10.16.06.37
- Fire Marshal Inspection (annual) COMAR 10.16.06.46
- Food Service Facility Permit from LHD (annual) COMAR 10.16.06.42
- Swimming Pool Permit from LHD (annual) COMAR 10.16.06.47

## *Facilities*

# Regulations 10.16.06.40

---

## **Sleeping facilities, COMAR 10.16.06.40**



- 1 bed, cot, or bunk per camper
- Sturdy frame with 12 inches from floor
- Provide min. of 30 square feet of floor space per occupant in sleeping areas
- Double Bunks: 27 inches bottom bunk to top bunk and 36 inches top bunk to ceiling
- Clean, vermin-free, hole-free mattress plastic mattress cover
- Disinfect mattresses annually

## Facilities

# Regulations 10.16.06.38 & .39

---

### **10.16.06.38 Toilet Facilities**

- Toilet facilities: If separate toilet facilities are provided they must be properly marked

### **10.16.06.39 Bathing and hand washing**

- Showerheads spaced min. of 30 inches apart
- Min. of 6 square feet of floor area
- Constructed of nonabsorbent, skid resistant, easily cleanable material
- Min. temp 90°F max. temp 120°F

| Type of Facility        | Day        | Residential |
|-------------------------|------------|-------------|
| 1 Toilet per            | 35 campers | 15 campers  |
| 1 Hand Washing Unit per | 35 campers | 25 campers  |
| 1 Showerhead per        | N/A        | 15 campers  |
| 1 Bed, Cot or Bunk per  | N/A        | 1 camper    |

## Garbage removal, COMAR 10.16.06.43

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- Durable containers in good repair
- Collected as necessary to prevent overflow
- Disposed of legally
- Outside containers have:
  - Tight-fitting Lids
  - Are leak-proof, fly-proof, and rodent-proof

## Insect and rodent control

---

COMAR 10.16.06.44



Minimize entry

Eliminate harborage

## **Fire and Other Hazards, COMAR 10.16.06.46**

---

- Fire Marshal Inspection (annual)
- All pesticides, chemicals, & toxic materials are:
  - properly labeled,
  - stored safely,
  - are not accessible to campers, &
  - only used by camp staff
  - SDS for each chemical are available for camp staff
- Camp is maintained to eliminate safety hazards



## Documentation for Private Building

---



### **The Local Health Approval Form:**

- **LHD must complete each season for:**
  - **Water supply if have an onsite well**
  - **Sewage disposal if have an onsite sewage disposal system, portable toilet, or privies**

## Food Service COMAR 10.16.06.42

---



All potentially hazardous camper food from home must be kept at 41F or below in a refrigerator

If a refrigerator is not provided, parents must receive a notice to send only non-perishable food to camp

## Documentation for School/Government

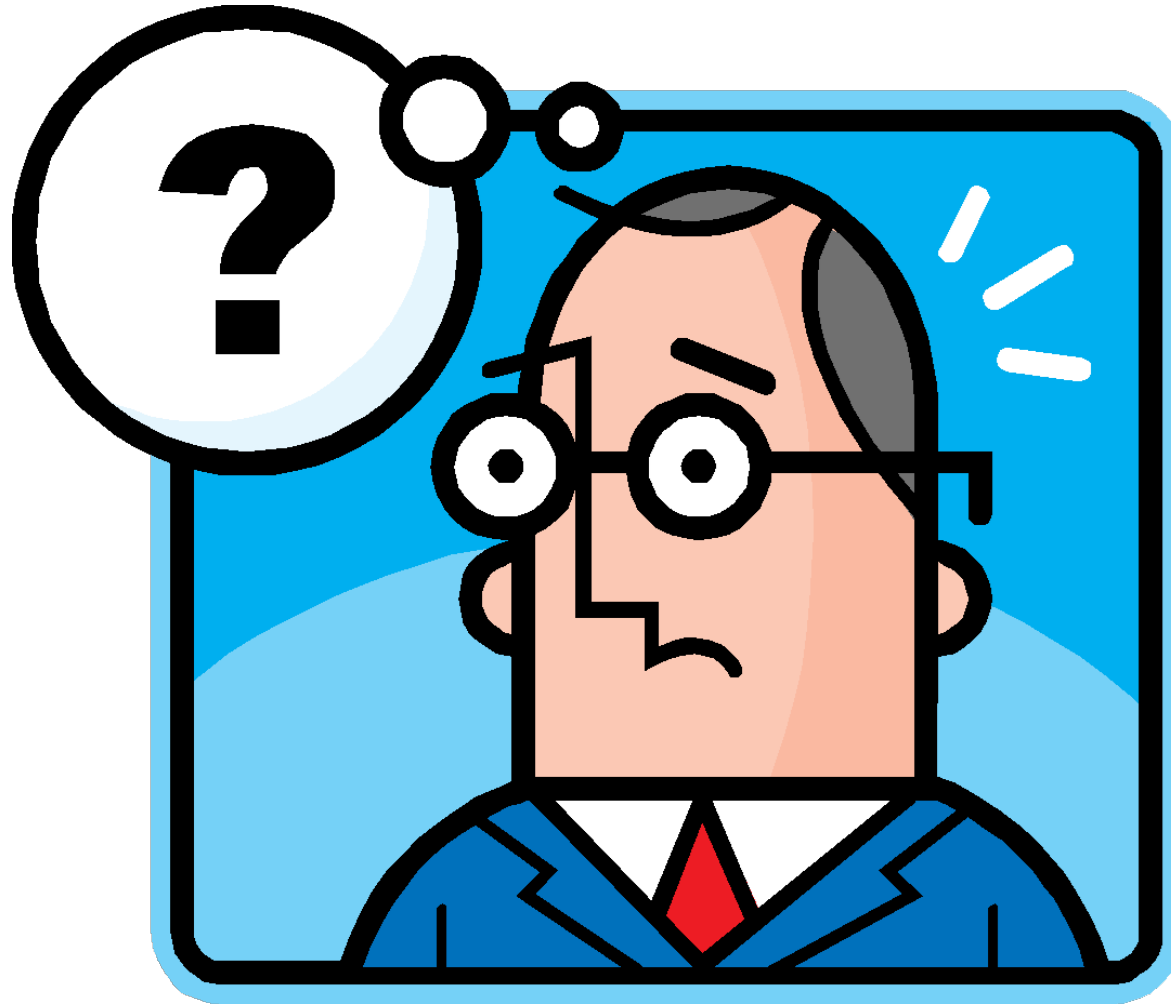
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- Building Safety Form (covers)
  - Water
  - Sewage Disposal
  - Plumbing
  - Electrical
  - Fire
  - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

*Facilities*

Questions?

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*Youth Camp Regulation Training*

**30 Minute Lunch Break**

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*Section 5*

# Health Program

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Health Supervisor

Required Staff

Written Health Program

Illness and communicable disease

Medication

Medication Fomss

Treatment Area

Health Records

Health Log

What is an Incident



## Health Supervisor

---

COMAR 10.16.07.04

- Doctor (MD)
- Nurse (RN)
- Nurse Practitioner (NP/ARNP)

### **Duties**

- Review & Approve Health Program Annually
- Oversee or Delegate Medication Administration
- Oversee Health Treatment Area
- Review Camper Health Forms
- Writes emergency action plans with parent/guardian consent

## CPR/First Aid

---

COMAR 10.16.07.04

### Minimum of 2 Adults

- Certification Issued by National Organization

### On Duty at All Times

- From 1<sup>st</sup> camper arrival to last camper pick up

### Field Trips

- One with trip and one at camp if campers stay behind

## Written Health Program

---

COMAR 10.16.07.03



1. Notify the camp health supervisor when a camper has an identified medical problem to ensure that there is a plan of action at the camp in case of a medical emergency;(action plan)
2. Disseminate information to staff members that work with a camper having a health problem;
3. Care for a camper with an identified medical problem;
4. Maintain confidentiality regarding all health information on campers and staff members;
5. Observe campers each day for easily discernible signs of injury or illness;

## Written Health Program

---

6. Handle health emergencies and accidents; to include

- Notify a parent, guardian, or the parent's or guardian's designee when a camper is observed to be injured or ill;
- Report health situations in accordance with Regulations .06 and .07 of this chapter; and
- Prevent the spread of an infectious disease using:
  - Hand washing procedures;
  - Personal protective equipment;
  - Personal hygiene; and
  - An exposure control plan;

7. Includes procedures for handling medication at camp



## Acute Illness and Communicable Disease Prevention

COMAR 10.16.07.03 and .12

- 1) Clean your hands often
- 2) Wash your hands with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
- 3) If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- 4) Avoid touching your eyes, nose, and mouth with unwashed hands.



## Acute Illness and Communicable Disease Prevention

---

COMAR 10.16.07.03 and .12

Clean and disinfect

Clean AND disinfect frequently touched surfaces daily. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.

If surfaces are dirty, clean them: Use detergent or soap and water prior to disinfection.



## Measles /Symptoms

---

- Fever.
- Dry cough.
- Runny nose.
- Sore throat.
- Inflamed eyes (conjunctivitis)
- Tiny white spots with bluish-white centers on a red background found inside the mouth on the inner lining of the cheek — also called Koplik's spots.
- A skin rash made up of large, flat blotches that often flow into one another

## Acute Illness and Communicable Disease Prevention



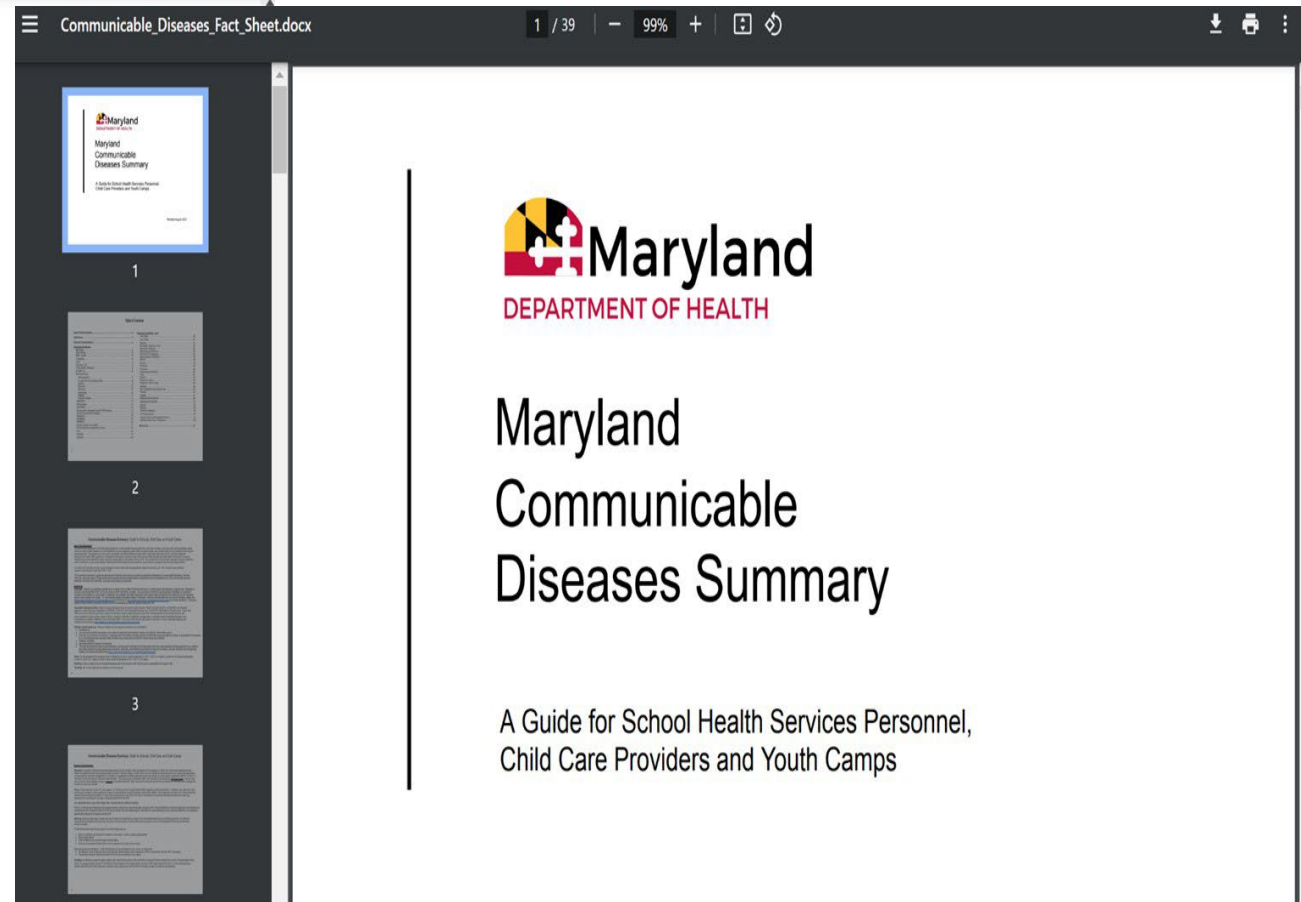
- [Application Fee Chart With Good Standing Reduced Fee \(01/2020\)](#)
- [How to Achieve Good Standing \(10/2017\)](#)
- [Self-Assessment for Youth Camp in Good Standing \(10/2022\)](#)

### Child Abuse Prevention

- [Child Abuse Prevention and Reporting Program \(10/2017\)](#)
- [Child Abuse Prevention and Reporting Self-Assessment Tool](#)
- [Child Protective Services](#)
- [What is Child Abuse Neglect](#)

### Health Care Information

- [Camper Health History Form - MDH-4768 \(06/2020\)](#)
- [Communicable Disease Summary \(10/2023\)](#)
- [Health Program Guidance \(04/2021\)](#)
- [Health Supervision and Medications FAQ. \(10/2017\)](#)
- [Immunization Certificate MDH-896 \(05/2021\)](#)
- [Required Reporting Chart](#)
- [Staff/Volunteer Health History Form MDH-4767 \(10/2022\)](#)
- [Sunscreen Memo \(01/2017\)](#)
- [Tick Bite Notification Form](#)



## Medications

---

COMAR 10.16.07.14

Covers Prescription and Nonprescription Medications

3 Types - Prescription, Emergency, and OTC (Over the Counter),

Self-administration vs. Staff Administration

Delegation ability varies depending on credentials of Health

Supervisor

Youth Camp Medication Administration Certificate Holder

## Medications

---

COMAR 10.16.07.14

Prescriptive Order for All Medication – MDH form

(may be used at multiple camps for one season)

Parental Consent Documented

Standing Orders and Parental Consent

Staff Medications

Sunscreen, see January 25, 2017 memo

# Medication Administration Authorization Forms

MDH-4578-A 3 Medications

MDH-4578-B 13 Medications

## MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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

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

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

| Section I. PRESCRIBER'S AUTHORIZATION   |  |       |   |                     |  |   |
|---|--|-------|---|---------------------|--|---|
| 1. CHILD'S NAME (First Middle Last)   |  |       | 2. DATE OF BIRTH (mm/dd/yyyy)                             |                     |  |   |
| 3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.   |  |       | 3a. FROM (mm/dd/yyyy)                                     | 3b. TO (mm/dd/yyyy) |  |   |
| Medication Name   | Condition Being Treated/PRN Parameters | Dose  | Route   | Frequency           | OK to Self-Administer  | OK to Self-Carry (Emerg Meds Only)  |
| 1   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 2   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 3   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 4. PRESCRIBER'S NAME/TITLE  |  |       | This space may be used for the Prescriber's Address Stamp |                     |  |   |
| TELEPHONE   |  | FAX   |   |                     |  |   |
| ADDRESS   |  |       |   |                     |  |   |
| CITY  |  | STATE | ZIP CODE  |                     |  |   |
| 5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)<br><small>(original signature or signature stamp only)</small>  |  |       |   |                     | 5b. DATE (mm/dd/yyyy)  |   |
| Section II. PARENT/GUARDIAN AUTHORIZATION   |  |       |   |                     |  |   |
| I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. |  |       |   |                     |  |   |
| 6a. PARENT/GUARDIAN SIGNATURE   |  |       | 6b. DATE (mm/dd/yyyy)                                     |                     | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION                                     |   |
| 6d. HOME PHONE #  |  |       | 6e. CELL PHONE #  |                     | 6f. WORK PHONE #   |   |
| Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)  |  |       |   |                     |  |   |
| THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.  |  |       |   |                     |  |   |
| I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."  |  |       |   |                     |  |   |
| 7a. PRESCRIBER'S SIGNATURE<br><small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>   |  |       | 7b. DATE  |                     | 8a. PARENT/GUARDIAN'S SIGNATURE<br><small>FOR SELF-ADMINISTRATION/SELF-CARRY</small> |   |
| MDH-4758-A (12/2019)  |  |       |   |                     | 8b. DATE   |   |

## MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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Draft Revision Date: 4/4/2018

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| 3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.   |  |       | 3a. FROM (mm/dd/yyyy)                                     | 3b. TO (mm/dd/yyyy) |  |   |
| Medication Name   | Condition Being Treated/PRN Parameters | Dose  | Route   | Frequency           | OK to Self-Administer                                    | OK to Self-Carry (Emerg Meds Only)  |
| 1   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 2   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 3   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 4   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 5   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 6   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 7   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 8   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 9   |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 10  |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 11  |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 12  |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 13  |  |       |   |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known side effects:   |  |       |   |                     |  |   |
| 4. PRESCRIBER'S NAME/TITLE  |  |       | This space may be used for the Prescriber's Address Stamp |                     |  |   |
| TELEPHONE   |  | FAX   |   |                     |  |   |
| ADDRESS   |  |       |   |                     |  |   |
| CITY  |  | STATE | ZIP CODE  |                     |  |   |
| 5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)<br><small>(original signature or signature stamp only)</small>  |  |       |   |                     | 5b. DATE (mm/dd/yyyy)                                    |   |
| Section II. PARENT/GUARDIAN AUTHORIZATION   |  |       |   |                     |  |   |
| I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. |  |       |   |                     |  |   |
| 6a. PARENT/GUARDIAN SIGNATURE   |  |       | 6b. DATE (mm/dd/yyyy)                                     |                     | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION         |   |
| 6d. HOME PHONE #  |  |       | 6e. CELL PHONE #  |                     | 6f. WORK PHONE #   |   |



# Health Program

# Asthma Action Plan

## ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Page 1 of 2

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities  
(410) 767-8417 or 1-877-463-3464 ext. 78417

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

|   |                      |                               |       |                             |  |  |
|---|----------------------|-------------------------------|-------|-----------------------------|--|--|
| 1. CHILD'S NAME (First Middle Last)   |                      | 2. DATE OF BIRTH (mm/dd/yyyy) |       | 3. PEAK FLOW PERSONAL BEST: |  |  |
| 4. ASTHMA SEVERITY (check one): <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced   |                      |                               |       |                             |  |  |
| 5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____ |                      |                               |       |                             |  |  |
| <b>Section I. ASTHMA ACTION PLAN</b>  |                      |                               |       |                             |  |  |
| 6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.  |                      |                               |       |                             |  |  |
|   |                      |                               |       | 6a. FROM (mm/dd/yyyy)       | 6b. TO (mm/dd/yyyy)                                      |  |
| <b>GREEN ZONE - DOING WELL</b>  |                      |                               |       |                             |  |  |
| You have <b>ALL</b> of these<br>Breathing is good<br>No cough or wheeze<br>Can walk, exercise, & play<br>Can sleep all night<br>If known, peak flow greater than _____ (80% personal best)  | Medication Name      | Dose                          | Route | Frequency                   | OK to Self-Administer                                    |  |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | Known side effects:  |                               |       |                             |  |  |
|   |                      |                               |       |                             |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <b>Exercise Zone</b>  |                      |                               |       |                             |  |  |
| <input type="checkbox"/> Prior to all exercise/sports<br><input type="checkbox"/> When the child feels they need it   | Rescue Medication    | Dose                          | Route | Frequency                   | OK to Self-Administer                                    | OK to Self-Carry   |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>YELLOW ZONE - GETTING WORSE</b>  |                      |                               |       |                             |  |  |
| You have <b>ANY</b> of these<br>Some problems breathing<br>Wheezing, noisy breathing<br>Tight chest<br>Cough or cold symptoms<br>Shortness of breath<br>Other: _____<br>If known, peak flow between _____ and _____ (50% to 79% personal best)  | Emergency Medication | Dose                          | Route | Frequency                   | OK to Self-Administer                                    | OK to Self-Carry   |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | Known side effects:  |                               |       |                             |  |  |
|   |                      |                               |       |                             |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>RED ZONE - MEDICAL ALERT/DANGER</b>  |                      |                               |       |                             |  |  |
| You have <b>ANY</b> of these<br>Breathing hard and fast<br>Lips or fingernails are blue<br>Trouble walking or talking<br>Medicine is not helping (15-20 mins?)<br>Other: _____<br>If known, peak flow below _____ (0% to 49% personal best)   | Emergency Medication | Dose                          | Route | Frequency                   | OK to Self-Administer                                    | OK to Self-Carry   |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | Known side effects:  |                               |       |                             |  |  |
|   |                      |                               |       |                             |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |                      |                               |       |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MDH-4758-C (01/2019)

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

Keep for 3 Years

## ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Page 2 of 2

Maryland Department of Health (MDH)  
Office of Healthy Homes and Communities  
(410) 767-8417 or 1-877-463-3464 ext. 78417

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

|   |       |   |   |
|---|-------|---|---|
| CHILD'S NAME (First Middle Last)  |       | DATE OF BIRTH (mm/dd/yyyy)                                |   |
| <b>Section II. PRESCRIBER'S AUTHORIZATION</b>   |       |   |   |
| 8. PRESCRIBER'S NAME/TITLE  |       | This space may be used for the Prescriber's Address Stamp |   |
| TELEPHONE   | FAX   |   |   |
| ADDRESS   |       |   |   |
| CITY  | STATE | ZIP CODE  |   |
| 9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)<br><small>(original signature or signature stamp only)</small>  |       |   | 9b. DATE (mm/dd/yyyy)                             |
| <b>Section III. PARENT/GUARDIAN AUTHORIZATION</b>   |       |   |   |
| I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. |       |   |   |
| 10a. PARENT/GUARDIAN SIGNATURE  |       | 10b. DATE (mm/dd/yyyy)                                    | 10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION |
| 10d. HOME PHONE #   |       | 10e. CELL PHONE #   | 10f. WORK PHONE #                                 |
| <b>Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)</b>  |       |   |   |
| THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.  |       |   |   |
| I authorize self-administration of all of the medications listed in Section I: Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."  |       |   |   |
| 11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY  |       |   | 11b. DATE (mm/dd/yyyy)                            |
| 12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY   |       |   | 12b. DATE (mm/dd/yyyy)                            |
| <b>Section V. CAMP MEDICAL STAFF USE ONLY</b>   |       |   |   |
| Camp Medical Staff Notes:   |       |   |   |
| Reviewed by:  |       |   | DATE (mm/dd/yyyy)                                 |

MDH-4758-C (01/2019)

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

Keep for 3 Years

# Health Program (Epi) Allergy Action Plan

Allergy Action Plan  
Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Is the child Asthmatic?  No  Yes (If Yes = Higher Risk for Severe Reaction)

Place Child's  
Picture Here

**TREATMENT**

| Symptoms:   | Give this Medication |               |
|---|----------------------|---------------|
| The child has ingested a food allergen or exposed to an allergy trigger:<br>But is <i>not</i> exhibiting or complaining of any symptoms | Epinephrine          | Antihistamine |
| Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")   |                      |               |
| Skin: hives, itchy rash, swelling of the face or extremities  |                      |               |
| Gut: nausea, abdominal cramps, vomiting, diarrhea   |                      |               |
| Throat: difficulty swallowing ("choking feeling"), hoarseness, hacking cough  |                      |               |
| Lung*: shortness of breath, repetitive coughing, wheezing   |                      |               |
| Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness  |                      |               |
| Other:  |                      |               |
| If reaction is progressing (several of the above areas affected)  |                      |               |

\*Potentially life-threatening. The severity of symptoms can quickly change.  
\*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

| Medication     | Dose: |
|----------------|-------|
| Epinephrine:   |       |
| Antihistamine: |       |
| Other:         |       |

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY CALLS**

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

|  | Contact(s)        | Name/Relationship | Phone Number(s) |      |
|--|-------------------|-------------------|-----------------|------|
|  |                   |                   | Daytime Number  | Cell |
|  | Parent/Guardian 1 |                   |                 |      |
|  | Parent/Guardian 2 |                   |                 |      |
|  | Emergency 1       |                   |                 |      |
|  | Emergency 2       |                   |                 |      |

**\*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.\***

Health Care Provider and Parent Authorization for Self-Carry Self Administration  
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer (school-aged only)  Yes  No

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



Allergy Action Plan  
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Is the child Asthmatic?  No  Yes (If Yes = Higher Risk for Severe Reaction)

Place Child's  
Picture Here

**The Child Care Facility will:**

- Reduce exposure to allergen(s) by: (no sharing food,
- Ensure proper hand washing procedures are followed.
- Observe and monitor child for any signs of allergic reaction(s).
- Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- Ensure that a person trained in Medication Administration accompanies child on any off-site activity.

**The Parent/Guardian will:**

- Ensure the child care facility has a sufficient supply of emergency medication.
- Replace medication prior to the expiration date
- Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.

**EpiPEN<sup>®</sup>**  
Epinephrine Auto-Injector 0.1/0.5mg user guide

1 Pull off the blue safety release cap.

2 Swing and firmly push the orange tip against the outer thigh so it clicks. HOLD on thigh for approximately 10 seconds to deliver the drug.  
**Remember:** As soon as you release pressure from the thigh, the protective cover will extend.

3 Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

**Call 911**

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit [epipen.com](http://epipen.com).

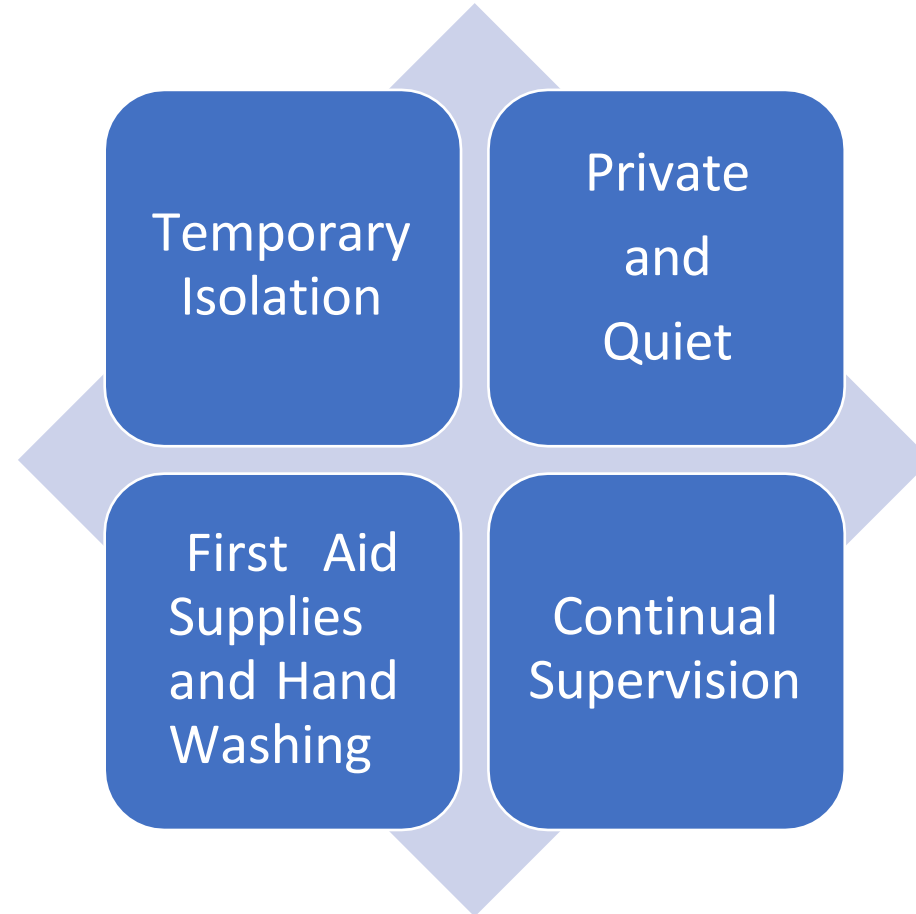
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# Treatment Area

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COMAR 10.16.07.13

## Day Camp

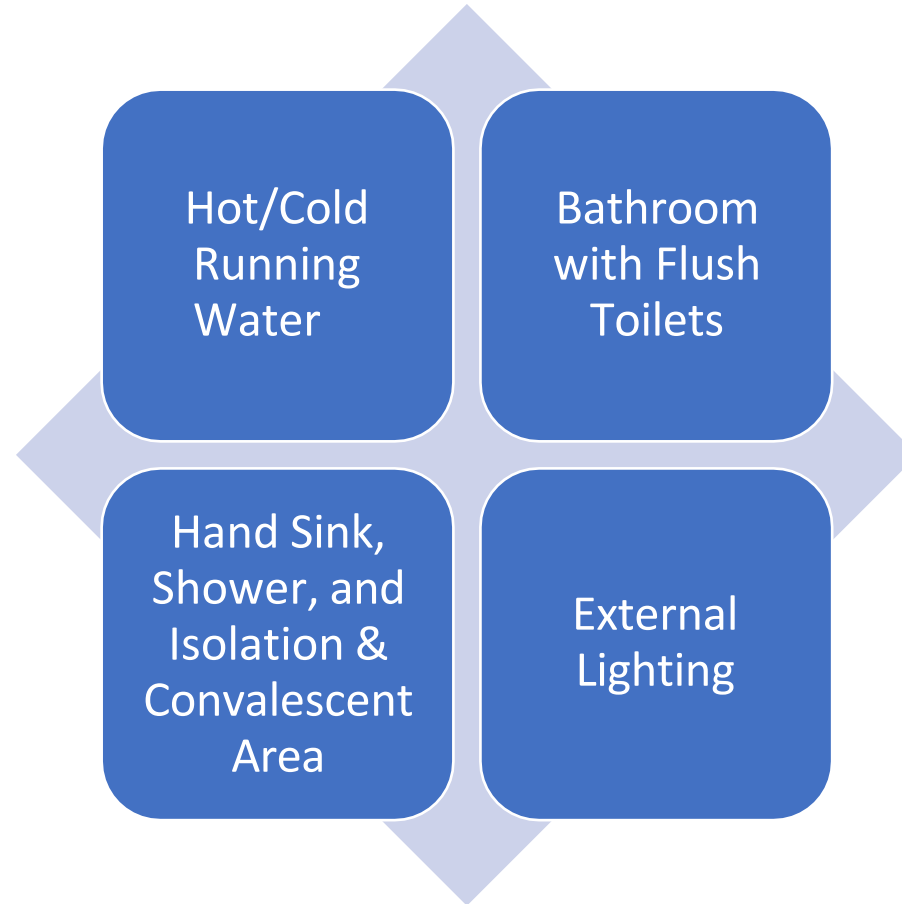


## Treatment Area

---

COMAR 10.16.07.13

# Residential Camp



# Health Program

## Health Records

### YOUTH CAMP HEALTH HISTORY CAMPER

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

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

#### EMERGENCY CONTACT INFORMATION:

Emergency Contact (Parent or Legal Guardian): \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

#### HEALTH INFORMATION:

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

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

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

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

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

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication?  YES  NO

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

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

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

MDH-4768 (12/2017)

### YOUTH CAMP HEALTH HISTORY STAFF MEMBER/VOLUNTEER

*Ensure all information is completed*

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

Current Residence: \_\_\_\_\_

#### EMERGENCY CONTACT INFORMATION:

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

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

#### HEALTH INFORMATION:

Are there any pertinent health problems including physical, psychiatric, or behavioral problems of which we need to be aware?

NO

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

Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?

NO

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

#### IMMUNIZATION INFORMATION:

**Must list current residence above.**

For staff members/volunteers who currently reside **within** the United States, a United States territory, or the District of Columbia: Do you have any immunization exemptions because of a parental or guardian objection or medical contraindication?

YES  NO

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

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

Staff Member/Volunteer Signature or Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years) \_\_\_\_\_ Date \_\_\_\_\_

MDH-4767 (10/2022)

COMAR 10.16.07.08 & .09


## Camper Health Record

## Staff/Volunteer Health Record

# Immunization

## Immunization Record - Form MDH 896

Document record of vaccination or immunity for campers who currently reside outside the United States, D.C., or U.S. territory.


  
**MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE**

STUDENT/SELF NAME: \_\_\_\_\_  
LAST FIRST M1

STUDENT/SELF ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: MALE  FEMALE  OTHER  BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

COUNTY: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

**FOR MINORS UNDER 18:**  
 PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

| # | DTP-01a-01<br>Mo/Day/Yr | Polio<br>Mo/Day/Yr | Hib<br>Mo/Day/Yr | Hep B<br>Mo/Day/Yr | PCV<br>Mo/Day/Yr | Rotavirus<br>Mo/Day/Yr | MCV<br>Mo/Day/Yr | HPV<br>Mo/Day/Yr | Hep A<br>Mo/Day/Yr | MMR<br>Mo/Day/Yr  | Varicella<br>Mo/Day/Yr | Varicella<br>Disease<br>Mo/Yr | COVID-19<br>Mo/Day/Yr |
|---|-------------------------|--------------------|------------------|--------------------|------------------|------------------------|------------------|------------------|--------------------|-------------------|------------------------|-------------------------------|-----------------------|
| 1 | DOSE #1                 | DOSE #1            | DOSE #1          | DOSE #1            | DOSE #1          | DOSE #1                | DOSE #1          | DOSE #1          | DOSE #1            | DOSE #1           | DOSE #1                |                               | DOSE #1 DOSE #2       |
| 2 | DOSE #2                 | DOSE #2            | DOSE #2          | DOSE #2            | DOSE #2          | DOSE #2                | DOSE #2          | DOSE #2          | DOSE #2            | DOSE #2           | DOSE #2                |                               | DOSE #2 DOSE #7       |
| 3 | DOSE #3                 | DOSE #3            | DOSE #3          | DOSE #3            | DOSE #3          | DOSE #3                | DOSE #3          | DOSE #3          | Td<br>Mo/Day/Yr    | Tdap<br>Mo/Day/Yr | MenB<br>Mo/Day/Yr      | Other<br>Mo/Day/Yr            | DOSE #3 DOSE #5       |
| 4 | DOSE #4                 | DOSE #4            | DOSE #4          | DOSE #4            | DOSE #4          |                        |                  |                  |                    |                   |                        |                               | DOSE #4 DOSE #5       |
| 5 | DOSE #5                 |                    |                  | DOSE #5            |                  |                        |                  |                  |                    |                   |                        |                               | DOSE #5 DOSE #10      |

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. \_\_\_\_\_  
 Signature Title Date  
(Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name  
 Office Address/ Phone Number

---

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**  
 Please check the appropriate box to describe the medical contraindication.  
 This is a:  Permanent condition OR  Temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**  
 I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

MDH Form 896 (Formerly DHMH 896)  
 Rev. 07/24
 Center for Immunization  
 www.health.maryland.gov/imm

# Health Log

---

COMAR 10.16.07.15



Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of  
Person Administering Care

Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages



## Health Log

---

- (1) Capturing the same required information as the paper record being replaced;
- (2) Password protected;
- (3) Accessed only by authorized staff members;
- (4) Permanent and will not be deleted;
- (5) Capable of tracking staff member use of the system and producing an auditable record;
- (6) Maintained in a confidential manner;
- (7) Available at all times for review by the Department upon request; and
- (8) Retained for a period of 3 years.

C. If the electronic record under §A of this regulation is unavailable for any reason - ?



**Electronic  
Forms**

## Incident Report

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- What is an Incident?
- When to Report?
- When to Report Acute Illnesses and Communicable Diseases?

Entered online in the Youth Camp Portal

(Details later in the presentation)

# Acute Illness & Communicable Disease

---

COMAR 10.16.07.12



Refer to list on MDH  
Youth Camp Website

## Health Program

# Incident Reports

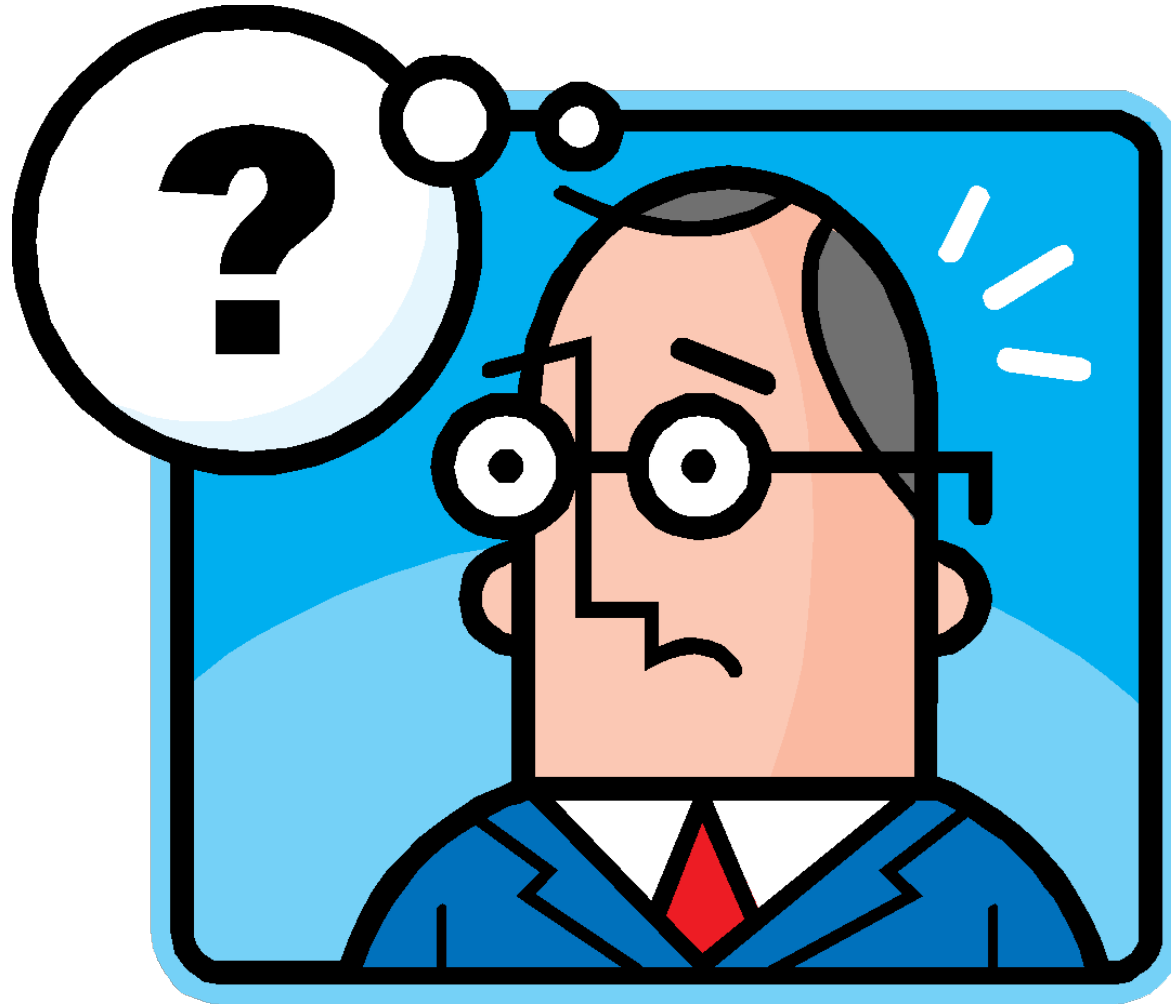
| Make Report To: ⇨<br>Type of Injury or Illness:   | Minor's Parent/Guardian or Adult's Emergency Contact   | Health Supervisor                                   | DHMH   | Health Log or Personal Health Record |
|---|--|---|--|--------------------------------------|
| CPR,<br>Admission to a hospital,<br>Death   | Immediately  | Immediately   | Verbally within 24 hours and submit the <b>Report Form*</b> within 1 week  | Record same day                      |
| Injury that is treated at an off-site medical facility and requires medical attention                       | Immediately  | Immediately   | Submit the <b>Report Form*</b> within 2 weeks of the end of camp   | Record same day                      |
| Accident with no apparent injury<br>Example: a fall from a horse/equipment or impact from sports equipment. | If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written) | Immediately if Health Supervisor is on duty at camp | No report  | Record same day                      |
| All other injuries & illnesses  | If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written) | No report   | No report  | Record same day                      |
| Reportable conditions or outbreaks per COMAR 10.06.01, see list   | Immediately  | Immediately   | Verbally to DHMH and Local Health Department within 24 hours and submit the <b>Report Form*</b> to DHMH within 1 week. | Record same day                      |
| Medication Error  | Immediately  | Immediately   | Submit the <b>Report Form*</b> within 2 weeks of the end of camp   | Record same day                      |

Maintain documentation of reports at camp.

*Health Program*

Questions?

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– *Section 6*

## Application Process

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Pre-Application / New Location

Community User

Youth Camp Portal

Application Walkthrough

Invoice Location

Required Documents

— *Application Process*

## Pre-Application / New Location

---

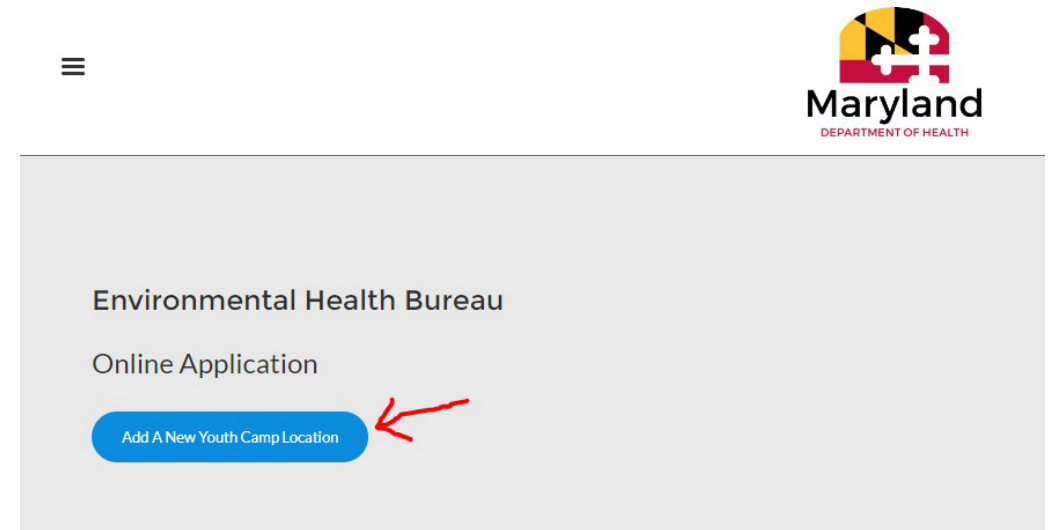
New Camp:

Complete the Pre-Application found on MDH Youth Camp webpage ‘Does my program require certification?’

New Camp Location:

Uses the ‘Add a New Youth Camp Location’ button when you log in to the Youth Camp Portal

Both will take you to the same questionnaire to enter the camp information into the Youth Camp Portal



– *Application Process*

## Community User

---

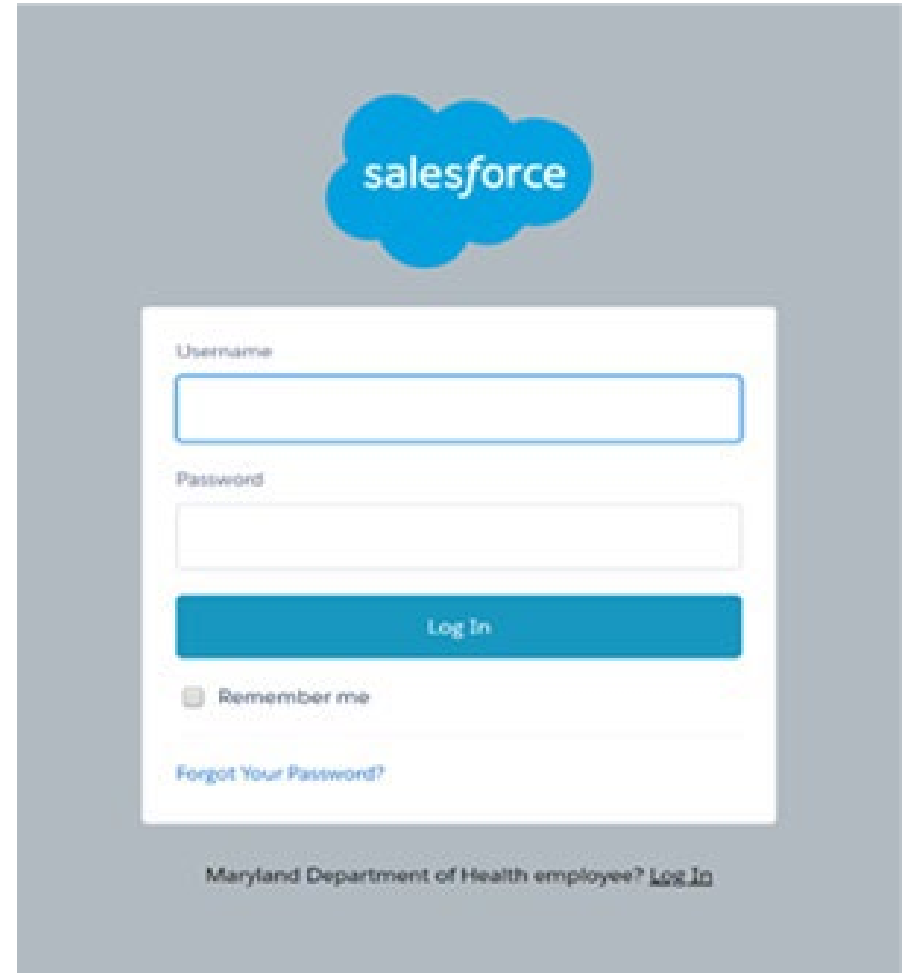
The Community User is the person who has access to the MDH youth camp portal and is responsible for entering the:

- annual application
- annual report
- incident reports
- uploading documents

A camp can only have 1 community user

A person can be the community user for more than one camp

Log In: <https://mdhyouthcamps.force.com/login>



The image shows a screenshot of a Salesforce login page. At the top center is the Salesforce logo, which consists of a blue cloud shape with the word "salesforce" in white lowercase letters. Below the logo is a white rectangular login form. The form contains the following elements: a "Username" label above a text input field; a "Password" label above a text input field; a blue "Log In" button; a "Remember me" checkbox; and a "Forgot Your Password?" link. At the bottom of the page, below the login form, is the text "Maryland Department of Health employee? Log In".

– *Application Process*

# Youth Camp Portal

To enter your youth camp, click on the name of the camp

For more than one camp location, click view all will show all the locations

Add a 'New Youth Camp Location' button found on this page

The screenshot shows the Maryland Department of Health Youth Camp Portal. At the top center is the Maryland Department of Health logo. Below it, the text reads "Environmental Health Bureau" and "Online Application". A blue button labeled "Add A New Youth Camp Location" is visible. To the right is an illustration of a yellow and blue tent. Below the main content area, there is a section titled "Youth Camp" with a sub-header "MY YOUTH CAMPS". A table lists one camp entry:

| Facility Name     | License Number | Physical Address                       | Camp Status |
|-------------------|----------------|--|-------------|
| Youth Camp Test12 | 02-YC-12822    | 6 Saint Paul Street Baltimore MD 21202 | Renewing    |

Below the table is a "View All" link.


# Application Process

 Facility  
**Test 11.3.23 Test**

- [+ Follow](#)
- [Application](#)
- [Create Annual Report](#)
- [Submit Background Check Application](#)

License Number: 30-TC-13708  
Physical Address: 6 St. Paul Street, Suite 1301  
Baltimore, Maryland 21202  
Camp Balance: \$380.00

## ▼ Youth Camp Information


Facility Name: **Test 11.3.23 Test** 


License Number: 30-TC-13708

Camp Balance: \$380.00

Fee Status: Regular

Enforcement Level: Compliant

Personnel Administrator   
Tom Jones

Verified Personnel Administrator 

Supervisor:  [Lindsey Wuest](#)

Inspector:  [Lindsey Wuest](#)

Camp Status: Renewing

Camp Type: Residential Camp

Camp Class: Certified

Regional:  [Angelese Davis](#)

Permit Type:

## Camp Applications (2)

| Camp Year | Application St... | Date Received | Camp Opening... |   |
|-----------|-------------------|---------------|-----------------|---|
| 2023      | Terminated        | 12/4/2023     | 12/7/2023       | ▼ |
| 2024      | Referred          | 2/13/2025     | 2/24/2025       | ▼ |

[View All](#)

## Annual Reports (1)

| Report #                      | Report Year | Total Camper ... | Completed An...                     |   |
|-------------------------------|-------------|------------------|-------------------------------------|---|
| <a href="#">RPT2023-13...</a> | 2023        | 1,575            | <input checked="" type="checkbox"/> | ▼ |

[View All](#)

– *Application Process*

# Youth Camp Portal

Camp Balance

Fee Status

Enforcement Level

Camp Status

Inspector

Community User

Personnel Administrator

▼ Youth Camp Information

Facility Name

Youth Camp Test11-21

License Number

04-YC-12911

Camp Balance

\$0.00

Fee Status

Regular

Enforcement Level

Compliant

Personnel Administrator ⓘ

Peter Parker

Verified Personnel Administrator ⓘ

Personnel Administrator Phone ⓘ

9099489919

Personnel Administrator Mobile ⓘ

Personnel Administrator Email ⓘ

vuth@enovational.com

Supervisor

Brian Flynn

Inspector

Clark Adelman

Camp Status

Renewing

Camp Type

Day and Residential Camp

Camp Class

Certified

Regional

Lindsey Linthicum

Permit Type

Certificate

Community user ⓘ

Peter Parker

Community User Phone ⓘ

9099489919

Community User Mobile ⓘ

Community User Email ⓘ

vuth@enovational.com

# Application Process

## Youth Camp Portal

Camp Applications

Annual Reports


Invoices


Incidents

Specialized Activities

Additional Camp Information


Files

 **Camp Applications (0)**

 **Annual Reports (3)**


| Report #                      | Report Year | Total Camper D... | Completed Ann...                    |
|-------------------------------|-------------|-------------------|-------------------------------------|
| <a href="#">RPT2022-12736</a> | 2021        | 0                 | <input type="checkbox"/>            |
| <a href="#">RPT2018-8166</a>  | 2017        | 610               | <input checked="" type="checkbox"/> |
| <a href="#">RPT2018-8163</a>  | 2016        | 1,585             | <input checked="" type="checkbox"/> |

[View All](#)


 **Invoices (1)**

| Invoice Number         | Camp Year | Amount due | Invoice Type        |
|------------------------|-----------|------------|---------------------|
| <a href="#">207961</a> | 2021      |            | Credit Voucher I... |

[View All](#)


 **Incidents (6)** [New](#)

| Youth Camp In...         | Created By       | B2/B3. Date/Ti...  | B1. Report Type |
|--------------------------|------------------|--------------------|-----------------|
| <a href="#">INC00368</a> | LindaTest Rudie9 | 7/10/2018 1:03 ... | Injury          |
| <a href="#">INC00435</a> | Linda Leichliter | 9/17/2018 8:40 ... | Injury          |
| <a href="#">INC00436</a> | Linda Leichliter | 9/17/2018 8:45 ... | Injury          |

 **Specialized Activities (4)** [New](#)


| Specialized Ac...       | Activity     | Specialized Acti... | Location                         |
|-------------------------|--------------|---------------------|----------------------------------|
| <a href="#">SA04389</a> | Archery      | Approved            | here <input type="checkbox"/>    |
| <a href="#">SA04392</a> | Wind Surfing | Approved            | bay <input type="checkbox"/>     |
| <a href="#">SA04411</a> | Canoeing     | Discontinued        | <input type="checkbox"/>         |
| <a href="#">SA04746</a> | Snow Skiing  | Pending             | on site <input type="checkbox"/> |


[View All](#)

 **Additional Camp Information (2)** [New](#)

| Additional Informatio...  | Created Date      | Created By                                |
|---------------------------|-------------------|---|
| <a href="#">ACI-00618</a> | 1/3/2023 11:21 AM | LindaTest Rudie9 <input type="checkbox"/> |
| <a href="#">ACI-00000</a> | 3/23/2020 2:28 PM | Salesforce Admin <input type="checkbox"/> |

[View All](#)

 **Files (1)** [Upload Files](#)

|  |
|--|
|  <a href="#">U&amp;O_WorldVie...</a><br>Sep 6, 2018 • ... |
|--|

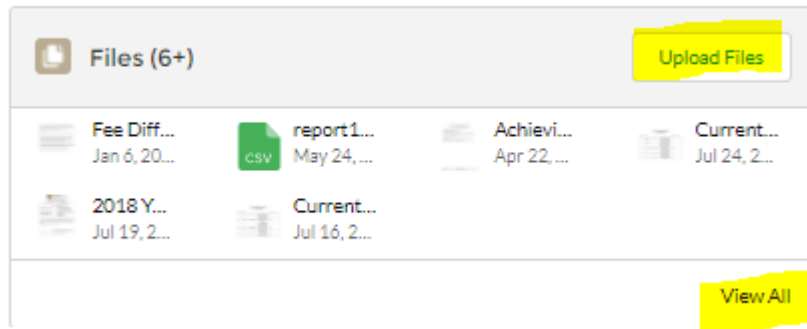
[View All](#)

– *Application Process*

# Youth Camp Portal

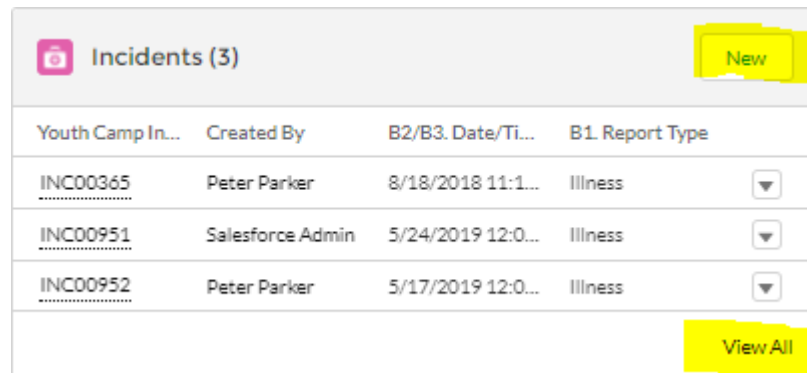
## Files- Upload Documentation

Safety Plans, Building Documentation  
(not Personnel information)



## Incident Report

Add a new report, see Required Reports



## Annual Report

Create new report with button at top right of page



To view Annual Report history: View All

Annual Reports (6+)

| Report #      | Report Year | Total Camper D... | Completed Ann... |
|---------------|-------------|-------------------|------------------|
| RPT2020-10696 | 2019        | 7,548             | ✓                |
| RPT2018-8177  | 2018        | 494               | ✓                |
| RPT2018-8176  | 2018        | 184               | ✓                |
| RPT2018-8175  | 2018        | 510               | ✓                |
| RPT2018-8174  | 2018        | 860               | ✓                |
| RPT2018-8173  | 2018        | 345               | ✓                |

View All

– *Application Process*

## Youth Camp Portal

---

### Additional Camp Information

- Camp contact information phone and email for the public
- Camp web page, social media and short camp description for the public
- Facility information - not public

### MDH Public Licensed Youth Camp Search

<https://mdhehb.gov.my.site.com/CampSearch/s/>

| Additional Camp Information (1) <span>New</span> |                   |              |   |
|--|-------------------|--------------|---|
| Additional Informatio...                         | Created Date      | Created By   |   |
| ACI-00299  | 11/6/2020 9:56 AM | Peter Parker | ▼ |
| <a href="#">View All</a>                         |                   |              |   |

### Youth Camps

---



The Maryland Department of Health Youth Camps Program regulates and licenses all youth camps in Maryland to protect the health and safety of kids attending Maryland youth camps. Have a question or concern? Please [contact us!](#)

#### Find a Youth Camp

Please click [Youth Camps Searchable Database](#) for information on Maryland licensed youth camps.

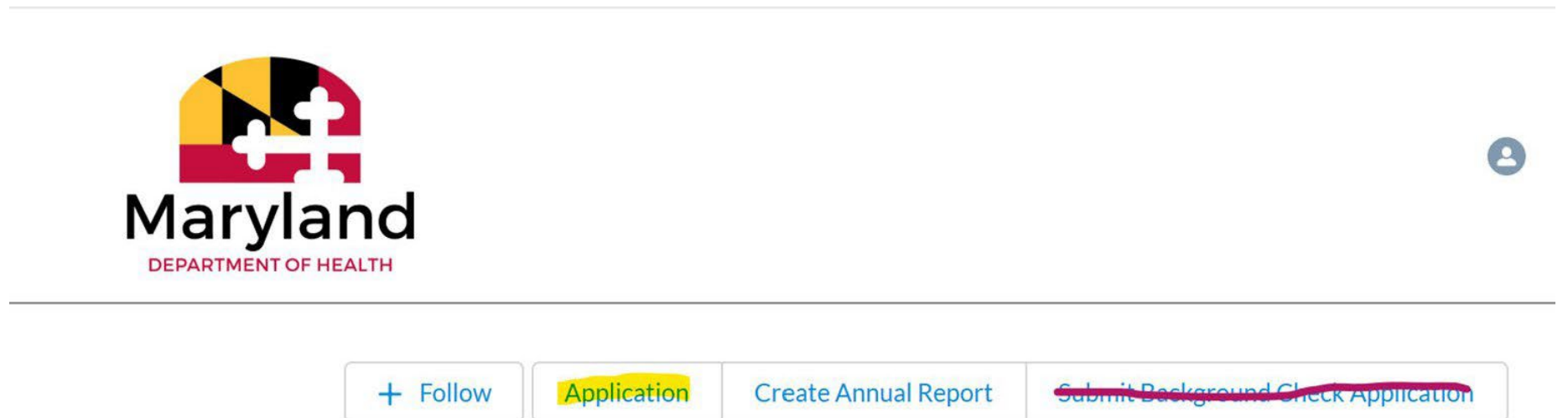
Parents should ask questions of any prospective youth camp to be comfortable that their child will be safe and have a positive, fun experience. In addition to verifying that a prospective youth camp is certified by MDH, the Youth Camp Safety Advisory Council created a [list of question for parents to use](#). If you would like information regarding a particular camp or need to make a complaint, please contact the Center for Recreation and Community Environmental Health Services at 410-767-8417.

## *Application Process*

# Application Walkthrough

---

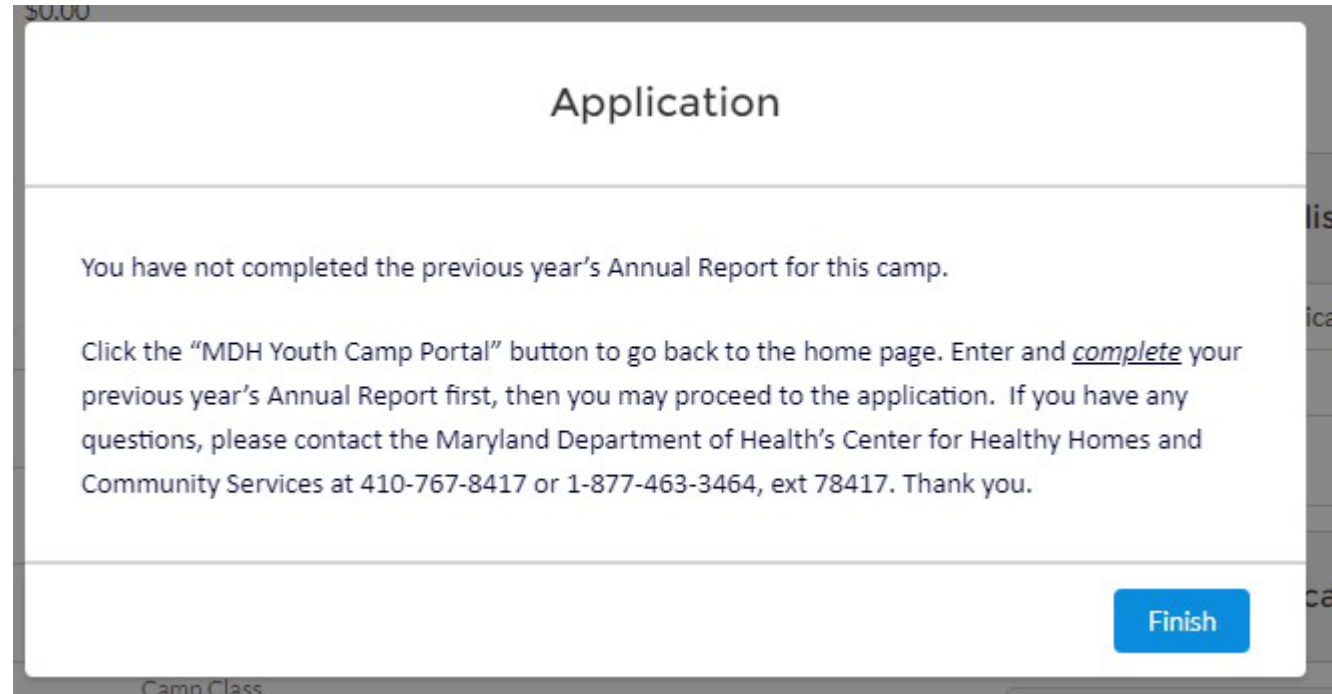
The Application button is at the top right of the page  
Click 'Application' and then select the year.



## Application Walkthrough

If you get this message, the previous year's Annual Report was not completed. Complete the annual report, then the application can be entered.

If the camp did not operate the previous year, email your MDH contact. Once the issue is resolved, the application can be entered.



# Application Process

## Application Walkthrough

### Youth Camp Application

#### Youth Camp Information

If any of the information is incorrect, please contact the Maryland Department of Health's Center for Healthy Homes and Community Services at 410-767-8417 or 1-877-463-3464, ext 78417. Thank you.

Youth Camp Name

ADELETE test

**License Number:**

02-YC-12917

**Camp Status**

Renewing

**Camp Class**

Certified

**Permit Type**

Certificate

#### Camp Type Information

**Day Camp:** Program is daily, no overnights

**Residential Camp:** Program is overnight, at least 4 nights

**Day and Residential Camp:** Program includes both day campers and overnight campers

**Trip Camp:** Program is overnight in which camper moves from one site to another under their own power or by transportation that permits individual guidance of a vehicle or animal

**Travel Camp:** Program is overnight and provides for campers to use motorized transportation to move as a group to a site or among sites for experience in different environments

\*Camp Type

### Youth Camp Application

#### Review And Update Your Information

**Camp Year**

2020

\* Camp Opening Date

\* Camp Closing Date

Date(s) Closed for Business

#### Child Care Center Present Information

If Yes - A child care center is operating at this site - Upload documentation that you notified the child care licensing office about your intent to operate a youth camp.

\*Child Care Center Present?

Child Care Center Present Information

 Or drop files

\*Are Camp Trips Provided?

# Application Walkthrough

New specialized activity.

If you are starting a new specialized activity and don't see it on the list, email your MDH contact

Youth Camp Application

**Do You Have New Specialized Activities?**

Yes  
 No

[Previous](#) [Next](#)

Youth Camp Application

**Check all new Specialized Activities.**

- Air Guns
- Archery
- Boating
- Canoeing
- Climbing Wall
- Cycling
- Fencing
- Go Karts
- Gymnastics
- Hang Gliding
- High Ropes
- Horseback Riding
- Kayaking
- Low Ropes
- Mountain Biking
- Mountain Boarding
- Paddle Boats
- Paintball
- Rappelling
- Riflery
- Road Cycling
- Rock Climbing
- Rock Wall
- Sailing
- Scuba
- Skateboarding
- Skating
- Snow Skiing
- Spelunking
- Standup Paddle Boarding
- Swimming - Natural Beach
- Swimming - Pool

## *Application Process*

# Application Walkthrough

---

### Youth Camp Application

By clicking Finish, I agree to comply with all applicable laws and regulations of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle, may result in an abatement order or closure order or denial, suspension, or revocation of youth camp certification or letter of compliance.

**Finish**

Click the Finish button to complete your application. The next page will have payment information and options to pay. If you have any questions, please contact the Department of Health's Center for Healthy Homes and Community Services at 410-767-8417 or 1-877-463-3464, ext 78417. Thank you.

# Application Process Youth Camp Portal

## Fee Payment / Invoice Location

Click on the invoice number to enter that invoice

Then click 'Pay Invoice' in the right corner

Click 'Pay Online Now' button to open the payment processor (credit card or ACH)

The screenshot shows the 'Youth Camp Information' page. On the left, there are fields for Facility Name (Youth Camp Test12), License Number (02-VC-12822), Camp Balance (\$5.00), Fee Status (Regular), Enforcement Level (Compliant), Personnel Administrator (Peter Parker), Verified Personnel Administrator (checked), Personnel Administrator Phone (9099489919), Personnel Administrator Mobile, and Personnel Administrator Email (vuth@enovational.com). On the right, there are fields for Supervisor (Michael McNeely), Inspector (Linda Rudie), Camp Status (Renewing), Camp Type (Day and Residential Camp), Camp Class (Certified), Regional (Nicole Alonge-Smart), Permit Type (Day), Community user (Peter Parker), Community User Phone (9099489919), and Community User Mobile. On the far right, there are sections for '2020 Checklist (0)', 'Camp Applications (0)', and 'Annual Reports (6+)'. The Annual Reports table has the following data:

| Report #      | Report Year | Total Camper D... | Completed Ann...                    |
|---------------|-------------|-------------------|-------------------------------------|
| RPT2020-10496 | 2019        | 7,548             | <input checked="" type="checkbox"/> |
| RPT2018-8177  | 2018        | 494               | <input checked="" type="checkbox"/> |
| RPT2018-8176  | 2018        | 184               | <input checked="" type="checkbox"/> |
| RPT2018-8175  | 2018        | 510               | <input checked="" type="checkbox"/> |
| RPT2018-8174  | 2018        | 860               | <input checked="" type="checkbox"/> |
| RPT2018-8173  | 2018        | 345               | <input checked="" type="checkbox"/> |

Below the table is an 'Invoices (1)' section with a table:

| Invoice Number | Camp Year | Amount due | Invoice Type       |
|----------------|-----------|------------|--------------------|
| 205121         | 2021      | \$5.00     | Renewal Applica... |

At the bottom right, there is an 'Incidents (3)' section with a 'New' button.

The screenshot shows the 'Youth Camp Invoice' page for invoice 205121. At the top right, there is a yellow 'Pay Invoice' button. Below the title, there is a summary table:

| Camp Year | Invoice Type            | Amount due | Total Paid | Balance Remaining |
|-----------|-------------------------|------------|------------|-------------------|
| 2021      | Renewal Application Fee | \$5.00     | \$0.00     | \$5.00            |

Below this is a detailed table with the following data:

| Invoice Number          | Amount due        |
|-------------------------|-------------------|
| 205121                  | \$5.00            |
| Camp Year               | Total Paid        |
| 2021                    | \$0.00            |
| Youth Camp              | Balance Remaining |
| Youth Camp Test12       | \$5.00            |
| Invoice Type            |                   |
| Renewal Application Fee |                   |

At the bottom right, there is a 'Payments (0)' section.

# Application Process

## Youth Camp Portal



Home




 Youth Camp Invoice  
206711

[Pay Invoice](#)

| Camp Year | Invoice Type          | Amount due | Total Paid | Balance Remaining |
|-----------|-----------------------|------------|------------|-------------------|
| 2020      | Credit Voucher Issued |            | \$0.00     | \$0.00            |

|                       |                   |
|-----------------------|-------------------|
| Invoice Number        | Amount due        |
| 206711                |                   |
| Camp Year             | Total Paid        |
| 2020                  | \$0.00            |
| Youth Camp            | Balance Remaining |
| <u>ADELETE test</u>   | \$0.00            |
| Invoice Type          |                   |
| Credit Voucher Issued |                   |

 Payments (0)

## Required Documents

---

### **Needs to be uploaded to the Youth Camp Portal:**

Fire Marshal Inspection (Annually)

Workers Compensation Insurance (Annually)

Building Documentation

LHD approval of well water / septic system (Annually, if well or septic)

Certification of 2 staff trained in CPR and first aid

Written health program signed by the health supervisor (Annually)

Written emergency procedures

Written child abuse prevention and reporting procedure

## Additional Documents

---

**Needs to be uploaded to the Youth Camp Portal, if applicable:**

Food service documentation (Annually)

On-site pool permit (Annually)

Trip Plan

Transportation Plan

Specialized Activity Plan

Primitive Camp Documentation

## MDH Website

---

### Key Resources!! Forms, Trainings, and Guidance Documents

#### \*\*Previously Most Requested Forms and Documents\*\*

- Guidance Documents
- Template Forms
- Helpful Information

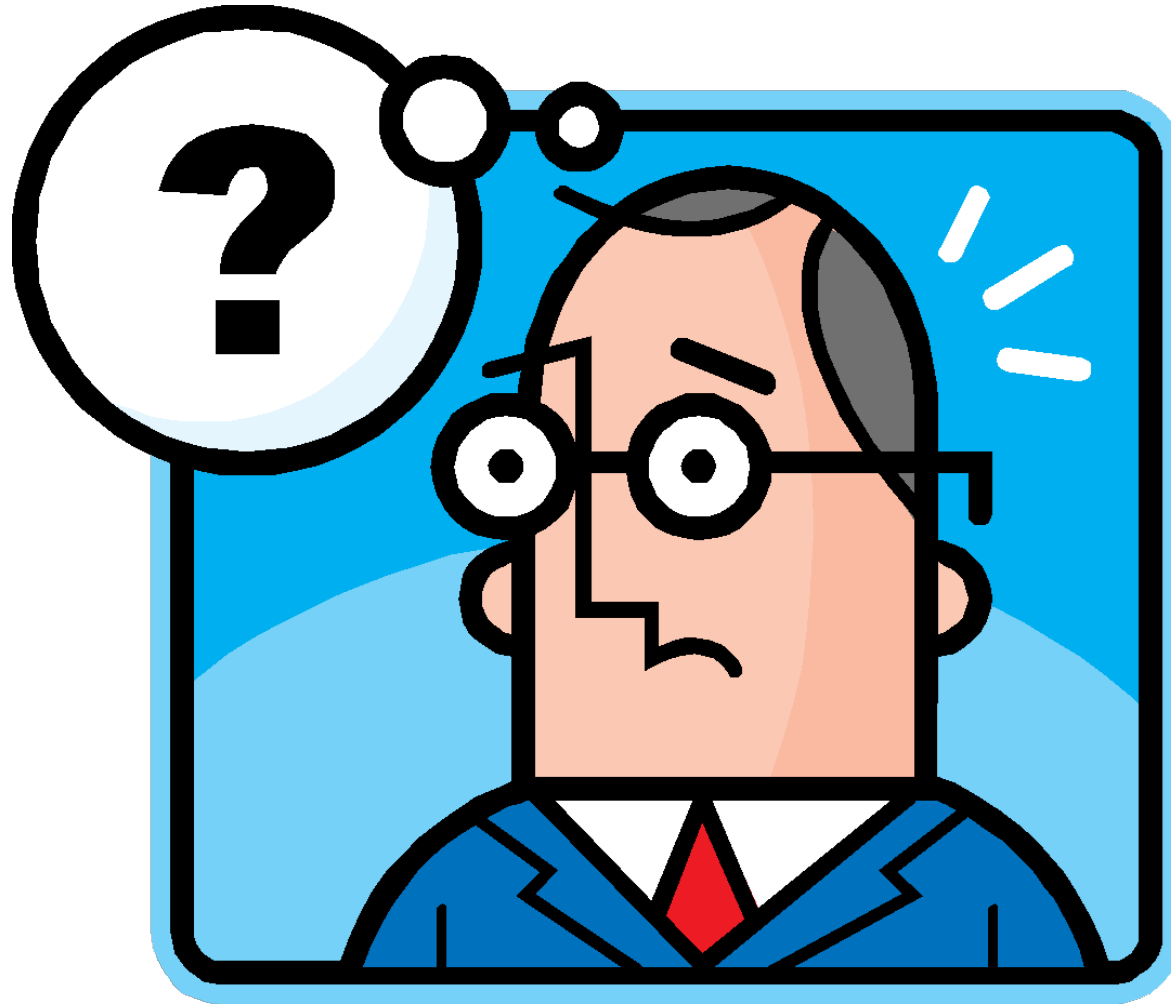
#### Key Links, Forms, Regulations, and Other Resources

- [MDH Youth Camps Web Portal](#) - Access your application materials, check on the status of your application, and access other key resources.
- Department of Human Resources -  
→ [Key resources!! Forms, trainings, and guidance documents](#)
  - Regulations trainings
  - Criminal Justice Information System (CJIS) Background Check
  - Child Protective Services (CPS) Background Check
  - Operator/Application Documents
  - Safety Plan Guidance
  - Youth Camp Good Standing Information
  - Health Care Information
  - Medication Administration Authorization Forms
  - Medication Administration Training Courses
- Code of Maryland Regulations (COMAR):
  - [10.16.06](#) - Certification for Youth Camps
  - [10.16.07](#) - Health and Medication Requirements for Youth Camps
  - [10.01.17](#) - Fees for Food Protection, Public Pools, Public Spas, Public Spray Grounds, and Youth Camp Programs
- Maryland Statute - [Md. Health-General Code Ann. §14-401 - §14-411](#)

*Application Process*

Questions?

---



— *Section 7*

## Youth Camp Inspection & Fees

---

Inspection Process

Inspection Frequency

Good Standing

Fee Explanation

Fee Chart

Reduced Fee / No Fee

## Inspection Process

---

COMAR 10.16.06.09

Camp inspections are not required to be scheduled, but summer inspectors may request information prior to the inspection.

During the inspection be prepared to:

- Provide a tour of the facility
- Allow time for the inspector to talk with staff about the plans and procedures
- Review staff background results and health history forms with the inspector
- Review safety plans and procedures with the inspector

The inspection reports (4 separate sections) will be emailed to the community user. Any violations observed during the inspection will be on the inspection reports.

## Staff Training & Certification

---

Document staff training for the following:

- Health Program
  - Including Medication Administration
- Emergency Plan
- Child Abuse Prevention and Reporting Plan

Upload training sign-in log to Youth Camp Portal

CPR and First Aid certification Staff

- 2 CPR/First Aid trained staff must be on duty during camp

Upload CPR and First Aid Certificates to the Youth Camp Portal

## Inspection Frequency

---

COMAR 10.16.06.09

Camps will receive an annual inspection from a MDH summer inspector

Except:

- Camps in 'Good Standing' with reduced fee will receive an inspection at least every 4 year by a MDH summer inspector

If MDH receives a complaint about a camp, the camp complaint will be investigated by a MDH summer inspector

## Good Standing

---

COMAR 10.16.06.02.B.17

A youth camp is in 'Good Standing' after 2 consecutive years of:

- Application submitted on time
  - New camp 60 days & Renewing 30 days before the first day of camp
- All fees paid
- No Critical Violations noted during inspection
- Annual Report submitted on time
  - Within 4 weeks of the end of camp
- Self-Assessment submitted on time
  - Within 4 weeks of the end of camp, on years camp did not receive a MDH inspection

## Good Standing

---

COMAR 10.16.06.02.B.17

### Benefits for a camp maintaining 'Good Standing'

- Inspection at least every 4 years, instead of annually.
- Reduced camp fee

## Fees Explanation

---

Fees are based on the number of camper days from the Annual Report.

Explain Calculating Camper Days (# of Days per Week X # of Weeks per Year X # of Campers per Week)

- Example 1: 5 days per week, 8 weeks per year, 10 campers  
( $5 \times 8 \times 10 = 400$  camper days)
- Example 2: 5 days per week, 10 weeks per year, 100 campers  
( $5 \times 10 \times 100 = 5,000$  camper days)

First year of camp has a base fee at the beginning of year and once the annual report is submitted a fee difference invoice, credit, or either

# Youth Camp Fee

## Fee Chart

COMAR 10.01.17.02B

| Maryland Department of Health                                     |              |              |
|---|--------------|--------------|
| Center for Recreation and Community Environmental Health Services |              |              |
| Youth Camp Application Fee Chart                                  |              |              |
| Effective January 1, 2017   |              |              |
| Day Camps   |              |              |
| Camper Days   | Regular Fee  | Reduced Fee  |
| <b>1 to 500</b>   | <b>\$190</b> | <b>\$45</b>  |
| 501 to 2,000  | \$500        | \$125        |
| 2,001 to 5,000  | \$665        | \$165        |
| 5,001 or more   | \$855        | \$215        |
| Residential, Day & Residential, Trip, or Travel Camps             |              |              |
| Camper Days   | Regular Fee  | Reduced Fee  |
| <b>1 to 700</b>   | <b>\$500</b> | <b>\$125</b> |
| 701 to 5,000  | \$1,000      | \$250        |
| 5,001 to 16,000   | \$1,500      | \$375        |
| 16,001 or more  | \$2,000      | \$500        |

Example 1: 400 camper days

Example 2: 5,000 camper days

## Reduced Fee / No Fee

---

COMAR 10.16.06.08

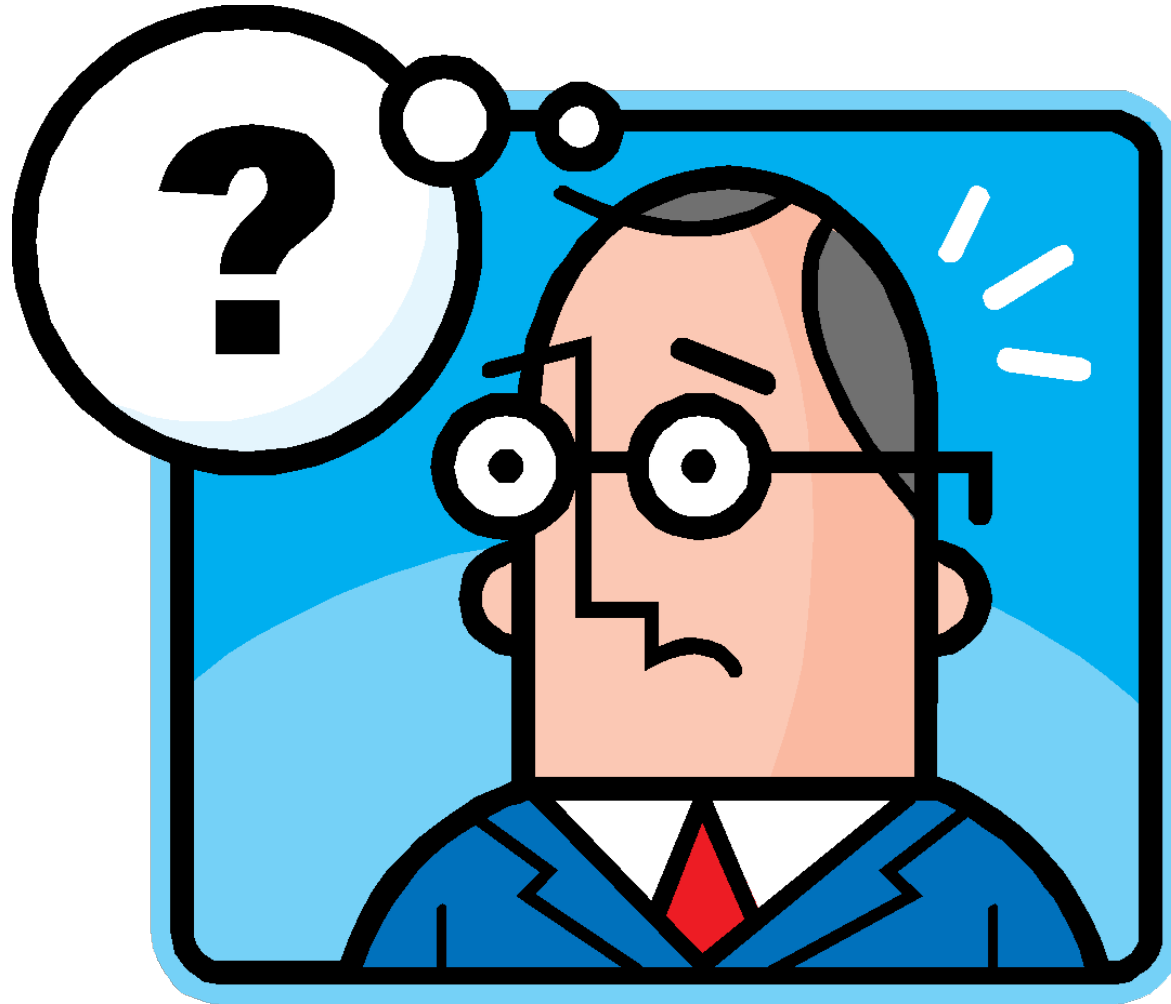
Camps that meet the requirements to be in 'good standing' for at least two consecutive years pay a reduced fee

Camps with an alternative accreditation (American Camp Association or Boy Scouts) do not pay the application fee

Camps operated by a unit of local government may opt for an Acceptance Letter (no fee) or Certificate (fee).

Questions?

---



– *Section 8*

## Required Reports

---

### Annual Report

COMAR 10.16.06.06

Annual Report must be submitted within 4 weeks of camp ending along with any required injury/illness reports.

### Incident Reports

COMAR 10.16.07.06

Injury, Illness, Medication Error, Epinephrine

## Required Report

# Annual Report - Where

- Annual reports should be entered online in the Youth Camp Portal.
- Create an annual report using the button at the top of the page.
- Edit an annual report by clicking on the report number.
- An annual report is only submitted after the complete box is checked.

The screenshot shows the Maryland Department of Health logo at the top left. Below the logo is a navigation bar with four buttons: "+ Follow", "Application", "Create Annual Report" (highlighted in yellow), and "Submit Background Check Application" (crossed out with a red line). Below the navigation bar is a section titled "Annual Reports (3)" with a table of reports. The table has four columns: "Report #", "Report Year", "Total Camper ...", and "Completed An...". The table contains three rows of data. The first row shows a report for 2021 with 0 campers and an unchecked "Completed An..." box. The second row shows a report for 2017 with 610 campers and a checked "Completed An..." box. The third row shows a report for 2016 with 1,585 campers and a checked "Completed An..." box. A "View All" link is located at the bottom right of the table.

| Report #      | Report Year | Total Camper ... | Completed An...                     |
|---------------|-------------|------------------|-------------------------------------|
| RPT2022-12... | 2021        | 0                | <input type="checkbox"/>            |
| RPT2018-81... | 2017        | 610              | <input checked="" type="checkbox"/> |
| RPT2018-81... | 2016        | 1,585            | <input checked="" type="checkbox"/> |

View All

## Required Report

# Annual Report - How

Ensure the:

- Start and end dates for the week make sense
- Closed days are correct
- Average number of campers for the week is entered

If a health item is entered, make sure an incident report has been completed

### Week 1

W1: Start Date

W1: # of Days

W1: # of Campers

W1: Camper Days

W1: # of Staff

W1: End Date

W1: # of Days Closed ⓘ

W1: # of Reportable Injuries ⓘ

W1: # of Reportable Diseases/Conditions ⓘ

W1: # of Medication Errors ⓘ

W1: # of Ephinerphine ⓘ

W1: # of Fatalities

| July 2023 |    |    |    |    |    |    | ^  | v |
|-----------|----|----|----|----|----|----|----|---|
| Su        | Mo | Tu | We | Th | Fr | Sa |    |   |
|           |    |    |    |    |    |    |    |   |
| 25        | 26 | 27 | 28 | 29 | 30 | 1  |    |   |
| W1:<br>0  | 2  | 3  | 4  | 5  | 6  | 7  | 8  |   |
| W1:<br>0  | 9  | 10 | 11 | 12 | 13 | 14 | 15 |   |
| W1:<br>0  | 16 | 17 | 18 | 19 | 20 | 21 | 22 |   |
| W1:<br>0  | 23 | 24 | 25 | 26 | 27 | 28 | 29 |   |
| W1:<br>0  | 30 | 31 | 1  | 2  | 3  | 4  | 5  |   |

## *Required Report*

# Annual Report - When

Annual report must be submitted in the Youth Camp Portal within 4 weeks of camp ending

Annual report can be entered weekly during camp or all at once at the end of camp

Annual report is only submitted when the box is checked

New Youth Camp Annual Report: Annual Report

|                        |   |
|------------------------|---|
| W12: # of Days<br>0    | W12: # of Days Closed ⓘ<br>0                    |
| W12: # of Campers<br>0 | W12: # of Reportable Injuries ⓘ<br>0            |
| W12: # of Staff<br>0   | W12: # of Reportable Diseases/Conditions ⓘ<br>0 |
|                        | W12: # of Medication Errors ⓘ<br>0              |
|                        | W12: # of Ephinerphine ⓘ<br>0                   |
|                        | W12: # of Fatalities<br>0                       |

**Completed Annual Report**

Completed Annual Report ⓘ

Completed Annual Report Date

Cancel Save & New Save

## *Required Report*

# Annual Report - Submitting

---

### ✓ Completed Annual Report

Completed Annual Report 



---

Completed Annual Report Date

---

#### Note

Before you check this report as "Completed", please Save the report and then review the data for accuracy.

The report will calculate the Camper Days for each week. If there are errors, select the Edit button at the top right of the form. After you have entered all data for this report and checked for accuracy, please check the box under Completed Annual Report.

You will not be able to Edit the report when Completed, contact the Office if you need to Edit after Completed Annual Report is checked.

---

# Required Report

## Incident Report - Where

▼ Youth Camp Information

|  |  |
|--|--|
| Facility Name<br>Test 11.3.23 Test                           | Supervisor<br>Lindsey Wuest                  |
| License Number<br>30-TC-13708                                | Inspector<br>Lindsey Wuest                   |
| Camp Balance<br>\$380.00                                     | Camp Status<br>Renewing                      |
| Fee Status<br>Regular  | Camp Type<br>Residential Camp                |
| Enforcement Level<br>Compliant                               | Camp Class<br>Certified                      |
| Personnel Administrator<br>Tom Jones                         | Regional<br>Angelese Davis                   |
| Verified Personnel Administrator<br><input type="checkbox"/> | Permit Type<br>Certificate                   |
| Personnel Administrator Phone<br>4103756541                  | Community user<br>Peter Parker               |
| Personnel Administrator Mobile                               | Community User Phone<br>9099489919           |
| Personnel Administrator Email<br>akasha0920@gmail.com        | Community User Mobile                        |
|  | Community User Email<br>vuth@enovational.com |

📄 Camp Applications (2)

| Camp Year | Application St... | Date Received | Camp Opening... |
|-----------|-------------------|---------------|-----------------|
| 2023      | Terminated        | 12/4/2023     | 12/7/2023       |
| 2024      | Referred          | 2/13/2025     | 2/24/2025       |

View All

👤 Annual Reports (1)

| Report #      | Report Year | Total Camper ... | Completed An...                     |
|---------------|-------------|------------------|-------------------------------------|
| RPT2023-13... | 2023        | 1,575            | <input checked="" type="checkbox"/> |


View All

📄 Invoices (3)

| Invoice Num... | Camp Year | Amount due | Invoice Type       |
|----------------|-----------|------------|--------------------|
| 212784         | 2024      | \$190.00   | Renewal Appli...   |
| 212699         | 2023      | \$0.00     | New Applicatio...  |
| 212785         | 2023      | \$190.00   | Invoice Fee Dif... |

View All

📄 Incidents (0) New



## Required Report

# Incident Report - How

New Youth Camp Incident: Youth Camp Incident Layout

**PERSONAL INFORMATION**

\* A1. Age  
10

\* A2. Gender  
Female

\* A3. Individual Type  
Day Camper

A3i. Individual Type Other

**INCIDENT INFORMATION**

Youth Camp Incident #

\* B1. Report Type  
Medication Error

\* B2/B3. Date/Time of Incident Onset  
Date Time

B4. Short Description

\* B6. Transported off-site?  
--None--

B6i. Transported by?  
--None--

View all dependencies

View all dependencies

Cancel Save & New Save

Ensure that B4 the short description is completed.

Ensure that all relevant questions are answered.

## Required Report

# Incident Reports - When

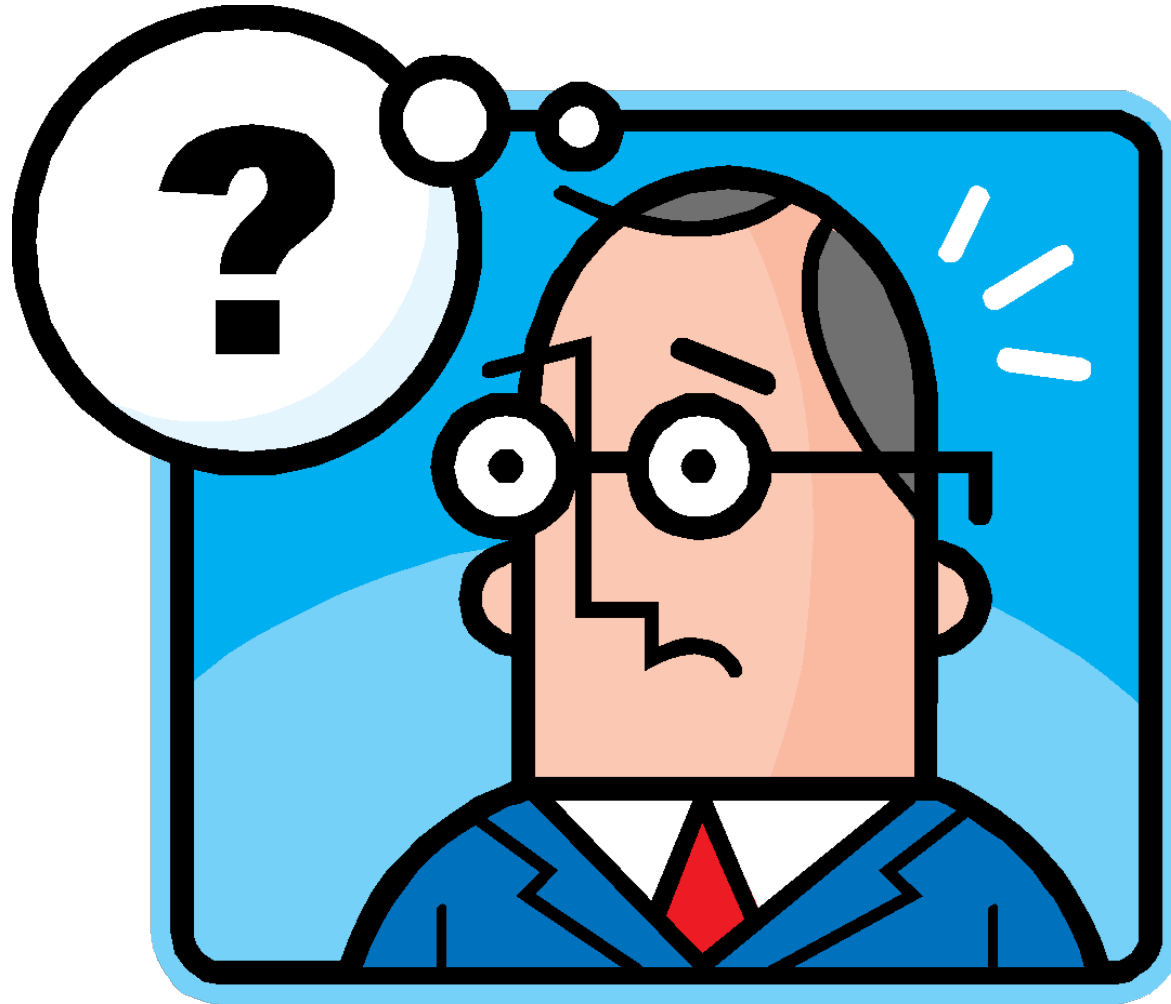
| Make Report To: ⇨<br>Type of Injury or Illness:   | Minor's Parent/Guardian or Adult's Emergency Contact   | Health Supervisor                                   | DHMH   | Health Log or Personal Health Record |
|---|--|---|--|--------------------------------------|
| CPR,<br>Admission to a hospital,<br>Death   | Immediately  | Immediately   | Verbally within 24 hours and submit the <b>Report Form*</b> within 1 week  | Record same day                      |
| Injury that is treated at an off-site medical facility and requires medical attention                       | Immediately  | Immediately   | Submit the <b>Report Form*</b> within 2 weeks of the end of camp   | Record same day                      |
| Accident with no apparent injury<br>Example: a fall from a horse/equipment or impact from sports equipment. | If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written) | Immediately if Health Supervisor is on duty at camp | No report  | Record same day                      |
| All other injuries & illnesses  | If Health Supervisor is not on duty at camp, ASAP and before end of camp day (verbal or written) | No report   | No report  | Record same day                      |
| Reportable conditions or outbreaks per COMAR 10.06.01, see list   | Immediately  | Immediately   | Verbally to DHMH and Local Health Department within 24 hours and submit the <b>Report Form*</b> to DHMH within 1 week. | Record same day                      |
| Medication Error  | Immediately  | Immediately   | Submit the <b>Report Form*</b> within 2 weeks of the end of camp   | Record same day                      |

Maintain documentation of reports at camp.

*Required Report*

Questions?

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# Youth Camp Website

[Health.Maryland.gov/youth-camps](https://Health.Maryland.gov/youth-camps)

## Youth Camps



The Maryland Department of Health Youth Camps Program regulates and licenses all youth camps in Maryland to protect the health and safety of kids attending Maryland youth camps. Have a question or concern? Please [contact us!](#)

### Find a Youth Camp

Please click [Youth Camps Searchable Database](#) for information on Maryland licensed youth camps.

Parents should ask questions of any prospective youth camp to be comfortable that their child will be safe and have a positive, fun experience. In addition to verifying that a prospective youth camp is certified by MDH, the Youth Camp Safety Advisory Council created a [list of question for parents to use](#). If you would like information regarding a particular camp or need to make a complaint, please contact the Center for Recreation and Community Environmental Health Services at 410-767-8417.

### Air Quality Alerts

Camps planning outdoor activities should be sure to check the [ambient air quality forecast](#).

### Contact Us

#### Center for Recreation and Community Environmental Health Services

Please contact us at (410)767-8417 or 1-877-463-3464, ext 78417 for assistance.

#### [Submit a Question](#)

Brian Flynn, Chief  
[Brian.Flynn@maryland.gov](mailto:Brian.Flynn@maryland.gov)

#### [Regional's Work Areas](#)

Michael McNeely  
[Michael.McNeely@maryland.gov](mailto:Michael.McNeely@maryland.gov)

Cecil, Montgomery, Somerset, Wicomico,  
& Worcester

Submit a Question

Regulation Training

Laws & Regulations

Certification Requirements

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Council Meetings

Most Requested Forms and Documents

Web Portals