BOSTON INSPECTIONAL SERVICES DEPARTMENT
DIVISION OF HEALTH INSPECTIONS - 4TH floor
1010 MASSACHUSETTS AVENUE
BOSTON, MA 02118
Phone (617) 635-5326 Fax (617) 635-5388

APPLICATION FOR RECREATIONAL CAMP LICENSE

DATE _____ PERMIT # _____

NAME OF CAMP _____ PHONE # _____

CAMP ADDRESS _____ CITY/TOWN _____ZIP_____

CAMP OWNER _____

FOR COMMUNITY CENTER (D/B/A)_____

MAILING ADDRESS _____CITY/TOWN _____ ZIP _____

WINTER PHONE # _____ EMAIL _____

CAMP DIRECTOR_____ ***__All Camp Operators__ are required to schedule a preliminary review and submit a revised policy and procedure manual prior to operating. Camp staff __must__ meet minimum requirements and provide documentation of training / experience in order to operate a camp.**

TYPE OF CAMP: Residential (Operates 24+ hours) _____ Day (Operates less than 24 hours) _____Sports _____ Travel/Trip _____
If you have a **medical camp** or any **special needs campers** please note the specific needs: _____

_____

Do you anticipate any overnights? Yes _____ No _____ Where? _____

Length of camp season: _____to _____ Hours:_____ A.M. _____P.M.
(start) **(finish)**
Number of sessions per season: _____ Session dates: _____

Camper Capacity __Per__ Session: _____ No. of Staff Persons: _____
(Max # of Campers) **(Supervising Campers)**
No. of volunteers: _____ Building Capacity: _____

Certificate of Inspection/Bldg. Division: Certificate No. _____ Expires _____

Date Recreational Camp Fire Dept. Inspection Completed _____ (BFD inspection information on-line)

What type of fire alarm, detector, or fire fighting equipment is present?

_____

Has the camp owner or director obtained and reviewed the new CORI /Juvenile report and SORI of every staff person and volunteer and determined a background free from disqualification?
Yes ____ No ____
Staff persons / volunteers cannot operate the camp until sufficient background checks are completed and cleared from disqualification. (*CORI / Juvenile and SORI reporting, work history, references-required for all staff / volunteers)

The Camp Director and staff meet eligibility criteria, have required training and have reviewed and understand the 105 CMR 430.000 Minimum Standards for Recreational Camps prior to camp operating Yes _____ No _____ If pending provide date_____

FOOD SERVICE:
Is food handled, served or prepared? Yes ____ No _____ Food Service Permit (provide copy) #_____

To what extent?

Snacks ____ Cooked and served by staff ____ Catered ____ If so, by whom? _____

Is refrigeration available for perishable foods? Yes _____ No _____ **(OVER)**

SWIMMING AREA:

Do you have or use recreational water facilities (beach, pool, lake, pond, water fountain or water park)? Check √ all that apply.
Fresh water _____ Ocean _____ Pool / Aquatics facilities_____ Other (explain) _____ None _____

If yes, locations of all beaches, water parks _____

If yes, location of pool / aquatics facility _____

Who is the **Aquatics Director** responsible for the supervision of the pool or swimming area(s)?

_____

Qualifications of Aquatics Director:

Water Safety instructor or equivalent …….. Yes _____ No _____

CPR Training …… Yes _____ No _____

First Aid Training …….. Yes _____ No _____

Name(s) of other on-site lifeguards and credentials:_____

_____

If swimming site(s) is not at the permanent camp, have the site(s) been inspected by regulatory agents and approved by the aquatics director and camp operator? Yes ____ No _____

Does the camp participate in any watercraft/boating activities? Yes ____ No _____

Include the camp itinerary and list specialized activities / travel plans below:

_____

_____

WATER SUPPLY: Public ____ Private _____
If private, date sampled _____ By whom? _____

Results _____

SHELTERS- DAY / RESIDENTIAL CAMPS: Meet(s) current building and housing requirements _____Yes
TOILET/SHOWER ROOMS: Number of toilets ……for males _____ for females _____

Handwash basins ……for males _____ for females _____

Showers ……..for males_____ for females _____

SEWAGE DISPOSAL: Public _____ Private _____ (please specify) _____

MEDICAL CARE: Who is responsible **at the camp** for medical care or first aid?

Name of Health Care Supervisor(s) available at each camp location_____

Name of Physician (qualifying Health Care Consultant) "on call": _____

Address _____ Phone No. _____

Name and address of **hospital** used for emergency services: _____

Does the camp have or contract with any transportation vehicles? Yes ____ No ____

Have you verified that the driver is properly licensed and meets required qualifications? Yes ____ No____

Schedule a preliminary review and provide a copy of required, annually updated policies and procedures for that appointment .

The annual $50. Recreational Camp fee is (check one) _____enclosed _____ already paid _____N/A

Signed: _____(**not valid** without owner / operator signature)

Incomplete and unsigned applications may not be eligible for issuance of a permit to operate. Date: _____