



# Certification for Youth Camps 2011

**Department of Health and Mental Hygiene**  
**Infectious Disease and Environmental Health Administration**

**Center for Consumer Health Services**

**6 Saint Paul St, Suite 1301**

**Baltimore, MD 21202-1608**

**Phone 410-767-8417**

**Fax 410-333-8926**



# Mission Statement

We work to improve the health of Marylanders by reducing the transmission of infectious diseases, helping impacted persons live longer, healthier lives, and protecting individuals and communities from environmental health hazards.

We work in partnership with local health departments, providers, and community based organizations to provide public health leadership in the prevention, control, monitoring, and treatment of infectious diseases and environmental health hazards.



# Legal Authority/Regulation

- Law: Youth Camp Act
- Regulation: COMAR 10.16.06
  - Last Updated in 2004
- Regulation: COMAR 10.01.17
  - Proposed Update in 2011



# Is My Program a “Youth Camp”?





# Is My Program a “Youth Camp”?





# What Is **NOT** a Youth Camp?

- 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
- A summer school program taught by certified teacher and offering credit



# Application

- New Youth Camp Application
  - Print from Youth Camp website  
[http://cha.maryland.gov/ofpchs/comm\\_srv/ycamp.cfm](http://cha.maryland.gov/ofpchs/comm_srv/ycamp.cfm)
  - Fill Out completely, accurately, attach all required supporting documents, & fee
- Renewal Applications
  - Renewal packages are sent to operator
- Applications not signed or submitted without fee will not be reviewed



# Procedures

## Health Program

- Regulations 10.16.06.22, through .33

## 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 Reporting

- Regulation 10.16.06.35



# Health Program

## Health Supervisor

COMAR 10.16.06.23

- Doctor
- Nurse
- Certified Nurse Practitioner
- **Duties**
  - Review & Approve Health Program Annually
  - Oversee or Delegate Medication Administration
  - Oversee Health Treatment Area
  - Review Camper Health Forms



# Health Program

## CPR/First Aid

**COMAR 10.16.06.23**

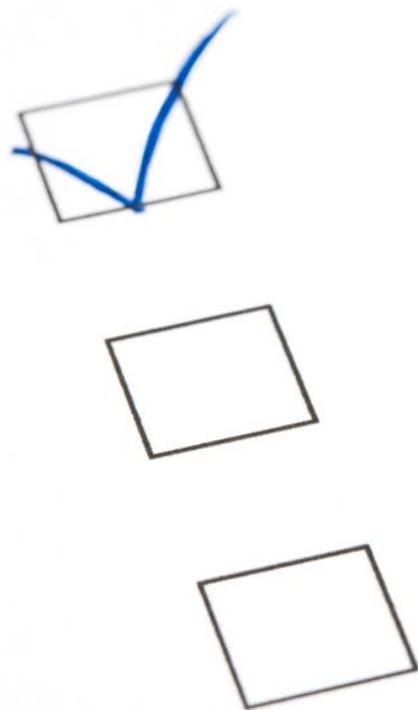
- Minimum of 2 Adults
- Certification Issued by National Organization
- On Duty at All Times
  - From 1<sup>st</sup> camper arrival to last camper pick up



# Health Program

## Written Health Program

**COMAR 10.16.06.22**



Refer to list of questions  
provided in your packet.



# Health Program

## Medications

**COMAR 10.16.06.33**

- Covers Prescription and Nonprescription Medicine
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Prescriptive Order for All Medication
- Parental Consent Documented



# Health Program

Treatment Area

COMAR 10.16.06.32

# Day Camp





# Health Program

Treatment Area

COMAR 10.16.06.32

# Residential Camp





# Health Program

## Health Records

### COMAR 10.16.06.27-.30

#### CAMPER HEALTH HISTORY

Child's name \_\_\_\_\_

The following information is required for a camper to be admitted to day camp:

#### CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see [www.EDCP.org](http://www.EDCP.org) (Immunization).

1. Provide date (month and year) of camper's last tetanus (or DTP) shot: \_\_\_\_\_
2. Is the camper currently enrolled in a Maryland school, public or private?
  - YES, provide name of Maryland school: \_\_\_\_\_
  - NO, provide a copy of immunizations confirming that the child has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See [www.EDCP.org](http://www.EDCP.org) (Immunization) for information.
3. Is the camper exempt from any immunization on medical or religious grounds?
  - YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.
  - NO

#### CONTACT INFORMATION:

Parent or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive:

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

#### CAMPER HEALTH HISTORY

Child's name \_\_\_\_\_

The following information is required for a camper to be admitted to residential camp:

#### CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see [www.EDCP.org](http://www.EDCP.org) (Immunization).

1. Provide a copy of immunizations confirming that the camper has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See [www.EDCP.org](http://www.EDCP.org) (Immunization) for information.
2. Is the camper exempt from any immunization on medical or religious grounds?
  - YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.
  - NO

#### CONTACT INFORMATION:

Parent or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive:

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



# Health Program

## Health Records

### COMAR 10.16.06.27-.30

STAFF OR VOLUNTEER HEALTH HISTORY

NAME \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff or Volunteer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STAFF OR VOLUNTEER UNDER 18

All staff or volunteers under 18 years old must be current on all immunizations.

1. Was staff/volunteer enrolled in a Maryland school, public or private, within the past year?

YES, provide name of Maryland school: \_\_\_\_\_

NO, provide a copy of immunizations confirming that the child has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See [www.EDCP.org](http://www.EDCP.org) (Immunization) for information.

2. Is staff/volunteer exempt from any immunization on medical or religious grounds?

YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons

NO

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



# Health Program

## Immunizations

### COMAR 10.16.06.28 & .30



#### Vaccine Requirements For Children

Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03

Maryland School Year 2011 - 2012 (Valid 9/1/11 - 8/31/12)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs									
Vaccine	DTaP/DIP/DT	Polio <sup>2</sup>	Hib <sup>5</sup>	Measles <sup>2,4</sup>	Mumps <sup>2,4</sup>	Rubella <sup>2,4</sup>	Varicella <sup>2,4,5</sup> (Chickenpox)	Hepatitis B	PCV <sup>3</sup> (Prenar <sup>TM</sup> ) <sup>6</sup>
Current Age of Child									
Less than 2 months	0	0	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	0	0	1	1
4 - 5 months	2	2	2	0	0	0	0	2	2
6 - 11 months	3	3	2	0	0	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
24 - 59 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	1
60 - 71 months	4	3	0	2	2	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12 <sup>th</sup> grade								
Grade Level	DTaP/DIP/Tdap/DT/Td <sup>1</sup>	Polio <sup>2,7</sup>	Measles <sup>2,4</sup>	Mumps <sup>2,4</sup>	Rubella <sup>2,4</sup>	Varicella <sup>2,4</sup> (Chickenpox)	Hepatitis B <sup>8</sup>	
(Ungraded)								
Kindergarten (5 yrs)	4	3	2	1	1	1	3	
Grades 1 - 12 (6 - 18+ yrs)	4 or 3 <sup>6</sup>	3	2	1	1	1 or 2 <sup>5</sup>	3	

\* See footnotes on back

Maryland Department of Health & Mental Hygiene  
Center for Immunization

www.EDCP.org (immunization)  
410-767-6679

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, Secretary



# Health Program

## Health Log

COMAR 10.16.06.24





# Health Program

## Injury/Illness Report

### COMAR 10.16.06.25 & .26

#### MARYLAND YOUTH CAMP INJURY OR ILLNESS REPORT FORM

Department of Health and Mental Hygiene (DHMH)/Center for Consumer Health Services (CHS)  
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608  
Phone 410-767-8417, Toll Free 1-877-6MD-CHMH, ext.8417 Fax 410-333-8826

► Before forwarding this report to DHMH, remove confidential information such as the person's name or other personal identifiers.

<b>A. PERSONAL INFORMATION</b>			
1. Name (print)	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper <input type="checkbox"/> Camp Employee <input type="checkbox"/> Other:
<b>B. INCIDENT INFORMATION</b>			
5. Report Type (check) <input type="checkbox"/> Injury <input type="checkbox"/> Illness	6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset : : : AM <input type="checkbox"/> PM <input type="checkbox"/>	
8. For injuries, specify how the injury occurred and what the injured person was doing at the time of the incident. For illness specify the symptoms and/or relevant medical conditions.			
<b>Additional information attached</b>			
9. Did the incident require any of the following: CPR - <input type="checkbox"/> No <input type="checkbox"/> Yes Epinephrine- <input type="checkbox"/> No <input type="checkbox"/> Yes AED - <input type="checkbox"/> No <input type="checkbox"/> Yes Inhaler - <input type="checkbox"/> No <input type="checkbox"/> Yes		15. What was the cause of injury: <input type="checkbox"/> Bite (by what) <input type="checkbox"/> Burn (by what) <input type="checkbox"/> Contact/interaction with Person <input type="checkbox"/> Contact/collision with Object (specify)	
10. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes List Date of death: / / List Time of death: : : am <input type="checkbox"/> pm		16. Was the injury: <input type="checkbox"/> Unintentional (accidental) <input type="checkbox"/> Intentional (self-inflicted) <input type="checkbox"/> Intentional (inflicted by another)	
11. Was the person transported off-site for medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete A. and B. A. Transported by: Camp or personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter B. Treated or evaluated at (check all that apply, specify the name of facility): <input type="checkbox"/> Urgent Care Facility <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify)		17. Did the individual sustain a (check all that apply): <input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> None of above	
12. After off-site or on-site medical evaluation, the person (check all that apply): <input type="checkbox"/> Was admitted to the hospital <input type="checkbox"/> Went home, Date: _____ <input type="checkbox"/> Returned to camp with medical restrictions <input type="checkbox"/> Returned to camp with no restrictions		18. Specify the body part(s) injured.	
13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes		19. Describe where the injury occurred: <input type="checkbox"/> On Site (specify location) <input type="checkbox"/> Off Site	
14. Did the incident prompt a report or investigation by government authorities or officials? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) Government Agency _____ Report/Investigation Date _____ Report/Investigation Number _____		20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity): <input type="checkbox"/> Archery <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Biking <input type="checkbox"/> Boating (specify) _____ <input type="checkbox"/> Competitive Sport/Game (specify): _____ <input type="checkbox"/> Cooking/Food Preparation <input type="checkbox"/> Lighting <input type="checkbox"/> General Camp Life (specify)	
<b>D. Complete Item 23 for an illness, not for an injury.</b>			
23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department. A. Was the illness a suspected reportable disease, condition or outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes For the required DHMH reportable diseases list and outbreak information go to: <a href="http://www.cdc.gov/dpdx/dpdx.html">http://www.cdc.gov/dpdx/dpdx.html</a> B. Was the illness reported to a local health department? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes (specify department): _____ The camp health supervisor or responding health care provider completes Provider Report Form # 1140, when reporting to the local agency go to: <a href="http://www.cdc.gov/dpdx/dpdx.html">http://www.cdc.gov/dpdx/dpdx.html</a>			
<b>E. GENERAL REPORT INFORMATION Complete Items 24 through 27 for an injury or illness.</b>			
24. Report Completed by Employee Name (print) _____ Title _____			
25. Camp Name _____ Address _____		DHMH CAMP ID # _____	
By Whom Notified	Parent, Guardian, or Emergency Contact was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____ Method _____
	Camp Health Supervisor was notified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Health Supervisor Name _____ Date _____ Method _____
	DHMH/CHS was notified within 24 hours	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	DHMH Contact Name _____ Date _____ Method _____
	27. Employee Signature _____	Date _____ Phone Number _____	

DHMH 10/2010

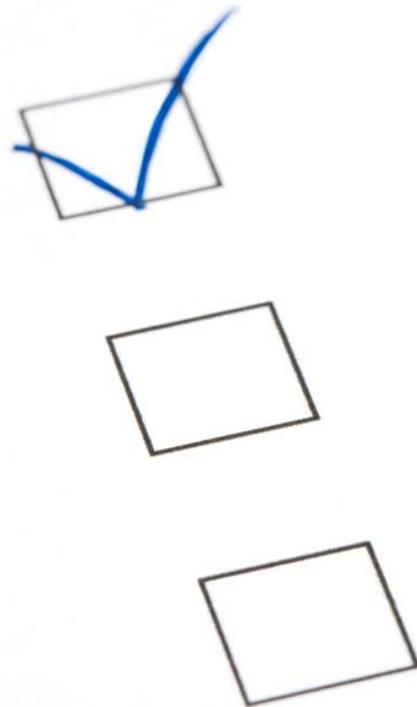
Maintain this report for at least 3 years.



# Health Program

## Acute Illness & Communicable Disease

COMAR 10.16.06.31



Refer to list provided in  
your packet.



# Emergency Procedures

- Regulation 10.16.06.34
  - Natural disasters and severe weather
  - Evacuation plan
  - Missing campers
  - 911
  - Transportation
  - Notify parents
  - Ensure camper safety



# Trip and Transportation

- Regulations 10.16.06.52, and .53
- Written Safety Plans for
  - Field trips
  - Specialized activities
- Written parental authorization
- Rules
- Supervision



# Specialized Activities

- Regulations 10.16.06.47, through .52
- Swimming
  - Written Swim Safety Plan
    - Director present
    - Swim ability test
    - Safety system to quickly account for campers
    - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding
- Other Specialized Activities



# Supervision and Reporting

- Supervision during routine activities
  - Regulation 10.16.06.54
- Child Abuse Reporting
  - Regulation 10.16.06.35



# Staff

- Training
  - Document staff training for the following:
    - Health Program
    - Emergency Plan
    - Trip and Transportation Plans
    - Specialized Activities Safety Plans
- CPR and First Aid certification
  - Document current CPR/first aid
  - Ensure that at least 2 adults with CPR/FA are on duty during camp



# Criminal Background Checks

COMAR 10.16.06.21



© Viviane Moos





# Authorization Number 180 Day Request

**For CJIS use Only**  
Authorization #:

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

GENERAL REGISTRATION FORM

I. COMPANY OR AGENCY NAME: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_  
(This is the person to whom all correspondence will be addressed)

CONTACT PERSON'S POSITION TITLE: \_\_\_\_\_

CONTACT PERSON'S TELEPHONE NUMBER: \_\_\_\_\_ EXT: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

II. REASON FOR REQUEST:

ADULT DEPENDENT CARE (For Maryland Adult Dependent Program ONLY)

ATTORNEY/CLIENT

CHILD CARE (For Maryland Child Care Facilities ONLY)

CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)

GOVERNMENT EMPLOYMENT (select one only)  Federal  State  Local

GOVERNMENT LICENSING/CERTIFICATION

PUBLIC HOUSING AUTHORITY

IF AUTHORIZED BY STATUTE, ENTER STATUTORY CITATION: \_\_\_\_\_

III. CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_

MAIL SIGNED AND COMPLETED FORM TO: CJIS AUTHORIZATION ADMINISTRATOR  
POST OFFICE BOX 32708  
PIKESVILLE, MARYLAND 21282-2708  
410 653 5690

OR FAX SIGNED AND COMPLETED FORM TO: 410 653 5690

Revised 3/4/03

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



180 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 \_\_\_\_\_  
(Mandatory, Required under MD Code Art. 27 710-715 and MD Regs. 13.15.01 To verify and preserve security of the record.)

REFERENCE NUMBER FROM MOST RECENT CHILD CARE APPLICATION FOR CRIMINAL HISTORY RECORD CHECK (THAT INCLUDED FINGERPRINTS) MUST BE WITHIN THE PAST 180 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: \_\_\_\_\_

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 Assistance Desk (410) 764-4591

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 before the effective date of October 1, 1995

\_\_\_\_\_ the application associated with this reference number was received more than 180 days before receipt of this request.

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





# Criminal Background Checks

NAME _____		CLASS _____		
ALIAS 0-459219		BLACK	MALE	
No. _____		COLOR _____	SEX _____	
REF 03/09/95		Loc: 32		
RIGHT HAND				
1. THUMB	2. INDEX FINGER	3. MIDDLE FINGER	4. RING FINGER	5. LITTLE FINGER
LEFT HAND				
6. THUMB	7. INDEX FINGER	8. MIDDLE FINGER	9. RING FINGER	10. LITTLE FINGER
TAKEN BY: <u>SIDEL</u>	NOTE AMPUTATIONS		SIGNATURE OF PERSON FINGERPRINTED	
CLASSIFIED BY: _____				
VERIFIED BY: _____				
FOUR FINGERS TAKEN SIMULTANEOUSLY LEFT HAND		L. THUMB R. THUMB	FOUR FINGERS TAKEN SIMULTANEOUSLY RIGHT HAND	

- Must have completed MD & FBI check for all required employees
- Copy of results must be addressed to employer, not the employee



# Criminal Background Checks

State of Maryland  
Department of Public Safety and Correctional Services



Martin O'Malley  
Governor

Anthony G. Brown  
Lt. Governor

Gary D. Maynard  
Secretary



G. Lawrence Franklin  
Deputy Secretary

Ronald C. Brothers  
Chief Info. Officer

C. Kevin Combs  
Deputy Chief Info. Officer

Carole Shelton  
Director

**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.dpscs.state.md.us](http://www.dpscs.state.md.us)

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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] - RC\_CJIS Fax: 410-465-4320

State of Maryland  
Department of Public Safety and Correctional Services



Martin O'Malley  
Governor

Anthony G. Brown  
Lt. Governor

Gary D. Maynard  
Secretary



G. Lawrence Franklin  
Deputy Secretary

Ronald C. Brothers  
Chief Info. Officer

C. Kevin Combs  
Deputy Chief Info. Officer

Carole Shelton  
Director

**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.dpscs.state.md.us](http://www.dpscs.state.md.us)

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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] - RC\_FBI Fax: 410-465-4320





# Facilities

- Required toilet ratio, COMAR 10.16.06.38
- Hand washing, COMAR 10.16.06.39
- Garbage removal, COMAR 10.16.06.43
- Insect and rodent control, COMAR 10.16.06.44
- Sleeping facilities, COMAR 10.16.06.40



# Documentation

- Building
- Water and sewage
- Plumbing
- Electrical
- Fire safety inspection
- Food Service



# Submitting Required Reports

- Annual Report must be sent to CHS within 2 weeks of camp ending.
- Submit injury/illness reports within 2 weeks of camp ending.



# Annual Report

- COMAR 10.16.06.06
- Must be filed with DHMH within 2 weeks of camp ending
- Report includes number of campers as well as other important information
- Ensure Injury/Illness Reports are also on file

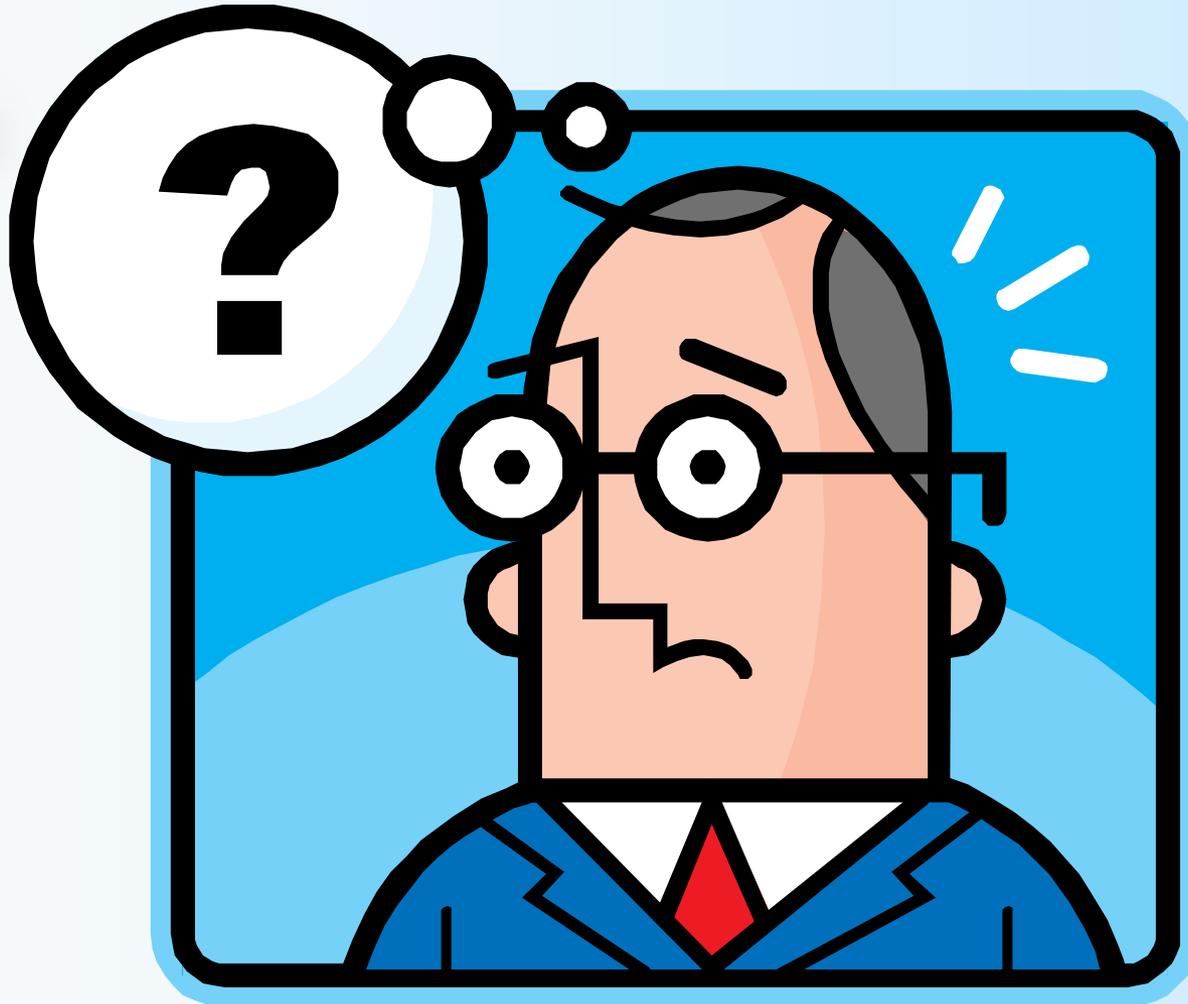


# Provisional Certification

- After all documents are approved provisional certificate is issued
- Valid for first operational period ONLY

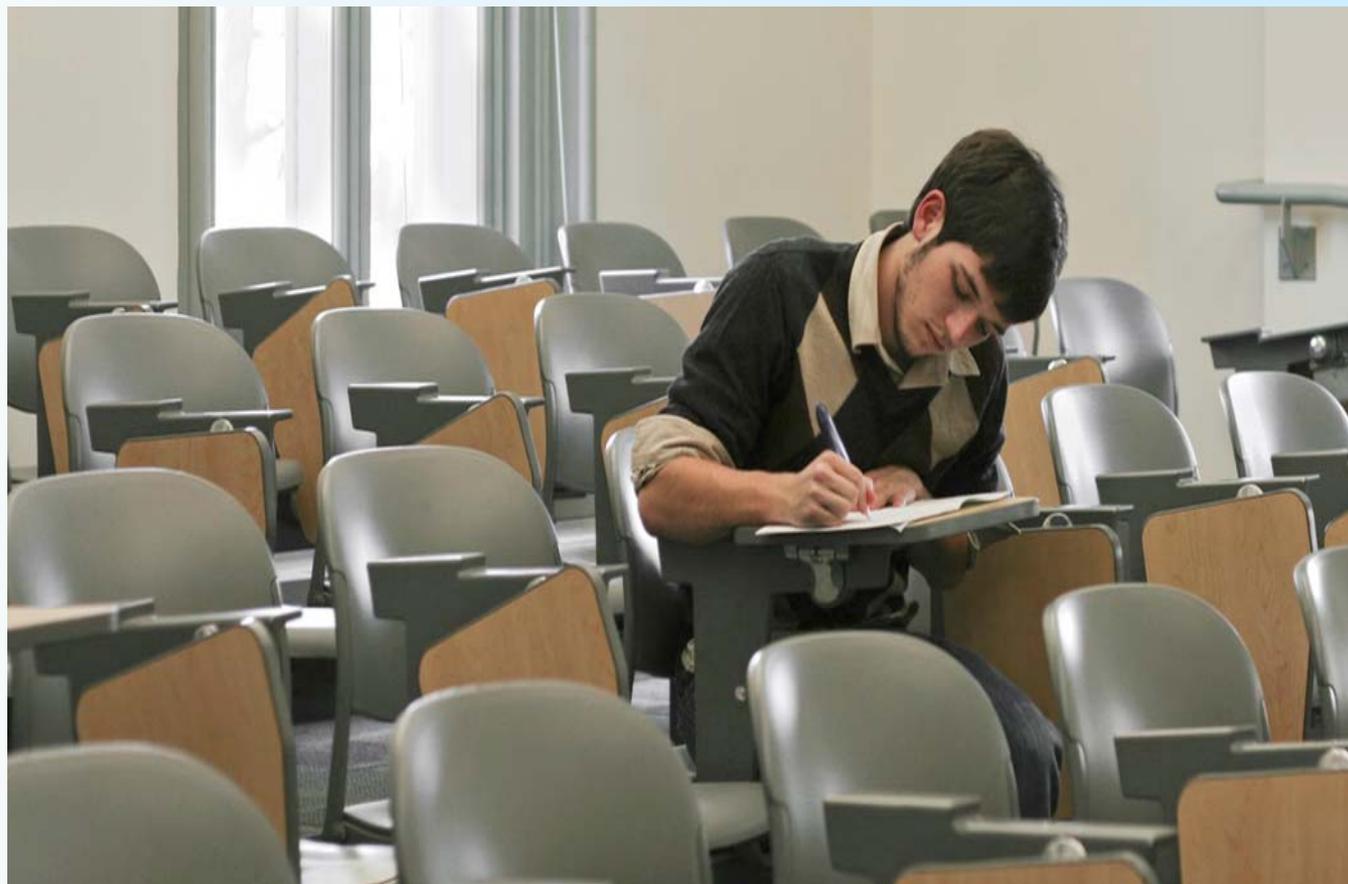


# Questions





# Post Test & Evaluation





# Post Test Review

