Summer Camp
Parent Handbook

Please detach and keep for your records

“This camp must comply with regulations of Massachusetts Department of Public Health and be licensed by the local board of health.”
The Charlestown Boys and Girls Club must comply with regulations of the MA Department of Public Health and be licensed by the local Board of Health.

Camp Director: Krishna Foran
Health Care Supervisors: Krishna Foran, Eric Davis, Alex Carbone, Taylor O'Neil

Summer Camp will run from Monday July 6th, 2020 through Friday, August 21st.

Camp Sessions
Mini Camp July 6th-10th
1. July 13th – July 24th
2. July 27th – August 7th
3. August 10th – August 21st

Camp hours
Camp hours are 9:00am to 4:00pm
Extended Care hours are 8:00am to 5:30pm

I understand that scheduled activities/field trips begin by 9:15am. If a camper arrives after 9:10am (without prior approval from the Camp Director), upon arrival that camper will be asked to leave for the day.

Safety
Our priority at the Charlestown Boys and Girls Club Summer Camp is to provide a safe, fun and healthy environment for our campers, visitors, and employees. To ensure the safety of our campers all employees are expected to obey all safety precautions when implementing summer camp activities.

- 1:5 staff to camper ratio for 6 year olds
- 1:10 staff to camper ratio for 7-12 year olds
- All campers must be signed in and out by an adult at the beginning and end of each day.
- A 1:25 lifeguard to swimmer ratio will be enforced at all times during swim, while still staying in the staff to camper ratio. Counselors and junior staff will be present to supervise swimmers during swim time.
- All lead staff are CPR and First Aid certified.
- A Health Supervisor will be on site at all times.
- Should an accident or injury occur at camp, a parent/guardian will be notified and a copy of the accident/injury report will be sent home upon request.

Field Trips
As part of your child’s programming two regularly scheduled out days are planned to various locations. By sending your child to camp you are allowing them to participate in any/all field trip(s) or related activities that happen during normal summer camp hours. These trips vary in nature and are under the supervision of Charlestown Boys and Girls Club staff; such trips are age and theme appropriate for all campers. On occasion, some field trips may run late due to unforeseen circumstances. If you do not want your child to attend a regularly scheduled out day, they will need to stay home from camp. You will receive a scheduled list of field trips for the summer prior to your child starting camp; which is subject to change.

“This camp must comply with regulations of Massachusetts Department of Public Health and be licensed by the local board of health.”
Camp Policies/Procedures

1. **Care of mildly ill campers**
2. **Administration of medications & Emergency care**
3. **Head Lice**
4. **Background Checks**
5. **Discipline, Suspension, Termination**
6. **Injury/Accident Reports**
7. **Bullying**
8. **Unregistered campers**
9. **How to file grievances**

1. **Care of mildly ill campers**

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

2. **Administration of Medication & Emergency Care**

   The designated Health Care Supervisor will administer any oral or topical medications. Health Care Supervisors have all been trained on proper medication administration by the Community Health Nurse from the Boys and Girls Clubs of Boston.

   In the event an injury occurs during Camp hours, the following emergency procedures will be implemented:

   **Emergency Procedures:**
   1) Staff will remain calm, stay with the victim and call for the assistance of other staff members.
   2) A designated staff member will call 911 and clear the area of campers while a staff member trained in CPR/First Aid will provided needed care to the injured camper.
   3) A Staff member will continue to keep injured person safe while waiting for EMS.
   4) A designated staff member will be at the main entrance of the building to direct EMS to the victim.
   5) All relevant emergency information will be available for EMS (including emergency release) - a staff member will accompany the camper to the hospital and stay until a parent/guardian or emergency contact person arrives.
   6) The Health Care Supervisor will notify the parent/guardian or emergency contact of the incident and which hospital their child is being treated at.
   7) An injury report will be filed according to policy 430.154.

**Emergency Procedures if parents cannot be contacted:**
1) Notify emergency contacts provided by parent/guardian that are on file.
2) Use the emergency release form with parent’s/guardian’s signature for EMS.
3) Continue to attempt to reach parent/guardian and document attempts.

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3. **Head Lice**

The Charlestown Boys and Girls Club may conduct periodic lice checks. If a child is found to have an active infestation, he/she will be excluded immediately from the club, the parent and/or guardian will be contacted by phone and asked to come to the club to dismiss their child. The parent and/or guardian will be given written instructions and a checklist will be given to assist them in eliminating the head lice problem. **For readmission to the club, the child must be accompanied by a parent and/or guardian, nit free and:**

- A. Be rechecked and cleared by the manager/director on-site
- OR
- B. Have a note from their primary care provider stating that the child is free of head lice and/or nits.

A copy of our more extensive head lice policy will be made available upon request.

4. **Background Checks**

Background checks, including CORI, SORI and National CORI and Juvenile Report, are completed for ALL staff, junior staff and volunteers. All documents are housed at the Boys and Girls Club Main Office, 200 High Street, 3rd Floor Boston, MA 02110, for a period of at least three years. No person is allowed to work until all the required background checks have been performed and the Director has been notified of the staff’s clearance to work.

A copy of our background check policy will be made available upon request.

5. **Discipline/ Suspension/ Termination**

All campers will be treated fairly and equitably. Lead counselors will establish clear and concise boundaries and expectations with all campers.

At the Club, we believe that if campers remember to respect themselves, fellow campers, the staff, the property, and visitors, then they are great role models for everyone. Below are other reminders on how your child can be a great camper: You can help us by reinforcing these messages at home.

1. **Respect:** All campers must respect other campers, staff, the building, and its property. This includes using positive and respectful language; keeping your hands, feet, and property to yourself.

2. **Bullying, teasing, picking on, and ganging up on others** will not be tolerated.

3. **Dress respectfully:** hats, headgear, bandanas, sagging pants, and half-shirts are not allowed. Shirts promoting drugs, sex, and/or violence are not allowed.

4. **Only go into areas that are supervised by staff and follow the expectations that are specific to each area.** Campers are expected to remain in their assigned rotation area until dismissed by the program staff.

5. **Listen to staff direction.**

6. **Keep all valuables and personal property at home (i.e., cell phone, portable gaming systems and other electronics).** The Club is not responsible for any lost or stolen articles.

7. **Try your best and support others in all activities**

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All discipline and guidance will remain consistent and be based on the child’s individual needs and development. The goal of discipline is to always maximize the growth and development of the child and to protect the group and the individuals within it.

A child’s attendance at camp is based on his/her behavior as well as the behavior of the parent/guardian. Campers and their families are expected to adhere to all rules, policies, and regulations set by the Club. A camper’s behavior outside of the Club may also influence membership status.

If a child’s behavior or other family representative’s behavior endangers the overall safety, security, and supervision of themselves and/or others, he/she may be dismissed from the Club upon review by staff and the directors. Being a camper is a privilege, and if a child cannot follow the club’s policies, rules, and expectations, his or her club membership may be revoked.

6. **Injury/Accident Reports**

A First Aid Kit will be located in every program area in the Boys and Girls Club.

A Health Care Supervisor or First Aid Trained staff will tend to all injuries, regardless of how small or insignificant injuries may appear. After treating the injury, the counselor will document the injury in the Camp Medical Log and an injury report will be filled out by the camp counselor. A parent or guardian will also be notified.

In the case an incident or injury warrants a 911 call, a parent or guardian will be immediately notified.

In the case of a suspected outbreak, staff will report symptoms to Health Supervisor, who will immediately notify the local Board of Health.

7. **If an unregistered child comes to Camp**

In the event an unregistered child arrives at Camp, all attempts will be made to contact the child’s parent or guardian. Unregistered children will not be allowed to participate in camp activities. An unregistered child under the age of 18 may participate in the Camps’ food program during breakfast and or lunch. All food must be consumed on site and parents may not take any food home.

8. **How to file grievances**

The Camp will immediately investigate all complaints/grievances and will take all steps necessary to remedy the situation. Grievances will be discussed with camp counselors and, if necessary, the camp director should be contacted directly, followed by the executive director.
What is meningococcal disease?
Meningococcal disease is caused by infection with bacteria called Neisseria meningitidis. These bacteria can infect the tissue (the “meninges”) that surrounds the brain and spinal cord and cause meningitis, or they may infect the blood or other organs of the body. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who survive, about 10-20% may lose limbs, become hard of hearing or deaf, have problems with their nervous system, including long term neurologic problems, or have seizures or strokes. Less common presentations include pneumonia and arthritis.

How is meningococcal disease spread?
These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing and sneezing.

Who is most at risk for getting meningococcal disease?
People who travel to certain parts of the world where the disease is very common, microbiologists, people with HIV infection and those exposed to meningococcal disease during an outbreak are at risk for meningococcal disease. Children and adults with damaged or removed spleens or persistent complement component deficiency (an inherited immune disorder) are at risk. Adolescents, and people who live in certain settings such as college freshmen living in dormitories and military recruits are at greater risk of disease from some of the serotypes.

Are camp attendees at increased risk for meningococcal disease?
Children attending day or residential camps are not considered to be at an increased risk for meningococcal disease because of their participation.

Is there a vaccine against meningococcal disease?
Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menevo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease, for age 10 and older.

Should my child or adolescent receive meningococcal vaccine?
That depends. Meningococcal conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. In addition, these vaccines may be recommended for children with certain high-risk health conditions, such as those described above. Otherwise, meningococcal vaccine is not recommended for attendance at camps.

Meningococcal serogroup B vaccine (Bexsero and Trumenba) is recommended for people with certain relatively rare high-risk health conditions (examples: persons with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited disorder), and people who may have been exposed during an outbreak). Adolescents and young adults (16 through 23 years of age) who do not have high risk conditions may be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection for most strains of serogroup B meningococcal disease. Parents of adolescents and children who are at higher risk of infection, because of certain medical conditions or other circumstances, should discuss vaccination with their child’s healthcare provider.

How can I protect my child or adolescent from getting meningococcal disease?
The best protection against meningococcal disease and many other infectious diseases is thorough and frequent handwashing, respiratory hygiene and cough etiquette. Individuals should:
1. wash their hands often, especially after using the toilet and before eating or preparing food (hands should be washed with soap and water or an alcohol-based hand gel or rub may be used if hands are not visibly dirty);
2. cover their nose and mouth with a tissue when coughing or sneezing and discard the tissue in a trash can; or if they don’t have a tissue, cough or sneeze into their upper sleeve.
3. not share food, drinks or eating utensils with other people, especially if they are ill.
4. contact their healthcare provider immediately if they have symptoms of meningococcal disease.

If your child is exposed to someone with meningococcal disease, antibiotics may be recommended to keep your child from getting sick.

You can obtain more information about meningococcal disease or vaccination from your healthcare provider, your local Board of Health (listed in the phone book under government), or the Massachusetts Department of Public Health Division of Epidemiology and Immunization at (617) 983-6800 or on the MDPH website at www.mass.gov/dph.

Provided by the Massachusetts Department of Public Health in accordance with M.G.L. c.111, s.219 and 105 CMR 430.157(C).

Massachusetts Department of Public Health, Divisions of Epidemiology and Immunization, 305 South Street, Jamaica Plain, MA 02130  Updated May 2018
Reviewed August 2019

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**Grades Kindergarten – 6**

In ungraded classrooms, Kindergarten requirements apply to all students ≥5 years.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>DTaP</td>
<td><strong>5 doses</strong>; 4 doses are acceptable if the 4&lt;sup&gt;th&lt;/sup&gt; dose is given on or after the 4&lt;sup&gt;th&lt;/sup&gt; birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP.</td>
</tr>
<tr>
<td>Polio</td>
<td><strong>4 doses</strong>; 4&lt;sup&gt;th&lt;/sup&gt; dose must be given on or after the 4&lt;sup&gt;th&lt;/sup&gt; birthday and ≥6 months after the previous dose, or a 5&lt;sup&gt;th&lt;/sup&gt; dose is required. 3 doses are acceptable if the 3&lt;sup&gt;rd&lt;/sup&gt; dose is given on or after the 4&lt;sup&gt;th&lt;/sup&gt; birthday and ≥6 months after the previous dose.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td><strong>3 doses</strong>; laboratory evidence of immunity acceptable</td>
</tr>
<tr>
<td>MMR</td>
<td><strong>2 doses</strong>; first dose must be given on or after the 1&lt;sup&gt;st&lt;/sup&gt; birthday and the 2&lt;sup&gt;nd&lt;/sup&gt; dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable</td>
</tr>
<tr>
<td>Varicella</td>
<td><strong>2 doses</strong>; first dose must be given on or after the 1&lt;sup&gt;st&lt;/sup&gt; birthday and 2&lt;sup&gt;nd&lt;/sup&gt; dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable</td>
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**Grades 7 – 12**

In ungraded classrooms, Grade 7 requirements apply to all students ≥12 years.

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<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>Tdap</td>
<td><strong>1 dose</strong>; and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been ≥10 years since Tdap.</td>
</tr>
<tr>
<td>Polio</td>
<td><strong>4 doses</strong>; 4&lt;sup&gt;th&lt;/sup&gt; dose must be given on or after the 4&lt;sup&gt;th&lt;/sup&gt; birthday and ≥6 months after the previous dose, or a 5&lt;sup&gt;th&lt;/sup&gt; dose is required. 3 doses are acceptable if the 3&lt;sup&gt;rd&lt;/sup&gt; dose is given on or after the 4&lt;sup&gt;th&lt;/sup&gt; birthday and ≥6 months after the previous dose.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td><strong>3 doses</strong>; laboratory evidence of immunity acceptable. 2 doses of Heplisav-B given on or after 18 years of age are acceptable.</td>
</tr>
<tr>
<td>MMR</td>
<td><strong>2 doses</strong>; first dose must be given on or after the 1&lt;sup&gt;st&lt;/sup&gt; birthday and the 2&lt;sup&gt;nd&lt;/sup&gt; dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable</td>
</tr>
<tr>
<td>Varicella</td>
<td><strong>2 doses</strong>; first dose must be given on or after the 1&lt;sup&gt;st&lt;/sup&gt; birthday and 2&lt;sup&gt;nd&lt;/sup&gt; dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable</td>
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**Campers, staff and volunteers 18 years of age and older**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td><strong>2 doses</strong>, anyone born in or after 1957. 1 dose, anyone born before 1957 outside the U.S. Anyone born in the U.S. before 1957 is considered immune. Laboratory evidence of immunity to measles, mumps and rubella is acceptable</td>
</tr>
<tr>
<td>Varicella</td>
<td><strong>2 doses</strong>, anyone born in or after 1980 in the U.S., and anyone born outside the U.S. Anyone born before 1980 in the U.S. is considered immune. A reliable history of chickenpox or laboratory evidence of immunity is acceptable</td>
</tr>
<tr>
<td>Tdap</td>
<td><strong>1 dose</strong>, and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule; Td should be given if it has been ≥10 years since Tdap</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td><strong>3 doses (or 2 doses of Heplisav-B) for staff whose responsibilities include first aid</strong>; laboratory evidence of immunity is acceptable</td>
</tr>
</tbody>
</table>

*A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee.

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