

CITY OF BOSTON  
MICHELLE WU, MAYOR  
MARTA E. RIVERA, COMMISSIONER

BCYF Blackstone  
BCYF Charlestown  
BCYF Clougherty Pool  
BCYF Condon  
BCYF Curley  
BCYF Curtis Hall  
BCYF Draper Pool  
BCYF Flaherty Pool  
BCYF Gallivan  
BCYF Beverly Gibbons  
BCYF Grove Hall  
BCYF Hennigan  
BCYF Holland  
BCYF Hyde Park  
BCYF Jackson/Mann  
BCYF Johnson  
BCYF Leahy-Holloran  
BCYF Marshall  
BCYF Mason Pool  
BCYF Mattahunt  
BCYF Menino  
BCYF Mildred Avenue  
BCYF Mirabella Pool  
BCYF Nazzaro  
BCYF Ohrenberger  
BCYF Paris Street  
BCYF Paris Street Pool  
BCYF Perkins  
BCYF Pino  
BCYF Quincy  
BCYF Roche  
BCYF Roslindale  
BCYF Shelburne  
BCYF Tobin  
BCYF Tynan  
BCYF Vine Street

Administrative Office  
1483 Tremont Street  
Boston, MA 02120  
Phone: 617-635-4920  
Boston.gov/BCYF  
@BCYFcenters  
Bluesky:  
@BCYF.boston.gov

Every Neighborhood,  
One Mission

February 2026

Dear Camp Joy Parents/Guardians:

Boston Centers for Youth & Families (BCYF) is committed to providing high-quality programming for residents of all ages and abilities in Boston. Since 1946 the Camp Joy program has provided thousands of Boston's youth with special needs an enriching summer camp experience.

The *BCYF Camp Joy Summer Program* focuses on the principles of inclusion, learning and fun. Trained, highly-skilled staff works to create a safe and nurturing environment for all participants. The *BCYF Camp Joy Summer program* is for Boston residents' ages 3—15 with disabilities and their siblings, 3-7 years old. The 4-week summer program provides structured, daily opportunities for participants to engage in recreational activities designed to promote peer-to-peer socialization, foster relationship building and support individual growth. Activities range from group games to gym time and arts and crafts.

For 2026, *The BCYF Camp Joy Summer Program* will be in session Monday-Friday from July 13-August 7, from 8am-2pm at a location TBD. Enrollment is on a first come, first served basis based on a completed application. **The parent fee for the first child is \$275.00 and \$80.00 for each sibling or Agency fee of \$350.00 per child. Money Orders only, NO REFUNDS. Please include Camper Photo along with Camp Joy Application.**

**Program Requirements:**

- Be between the ages of 3-15 for youth with disabilities;
- Be able to interact in a 4:1 participant to staff ratio;
- Be a Boston resident (proof of residency required );
- Complete application with all documentation and signatures;
- Campers that are 3 to 8 years old, or under 57 inches must have a car seat or booster seat. Campers that are taller than 57 inches can use a vehicle seat belt.

For more information about the BCYF Camp Joy Summer Program or to request an application please contact me at [Roberta.Smalls@Boston.gov](mailto:Roberta.Smalls@Boston.gov) or (617) 961-6952.

Sincerely,

Roberta Smalls  
BCYF Camp Joy Program Manager

*BCYF does not discriminate on the basis of race, creed, color, national origin, ability, sex, secular preference, sexual orientation, marital status, age, political affiliation or religion, in accordance with the non-discrimination requirements of applicable statute. "This camp complies with regulations of the Massachusetts Department of Public Health and is licensed by the local board of health."*

# BCYF Camp Joy Summer 2026

Session Dates: Monday, July 13 – Friday, August 7



## CAMPER APPLICATION

Please mail or drop-off original applications to:  
Faxed applications will not be accepted

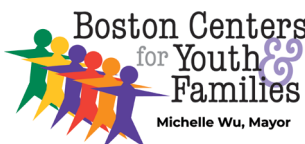
Boston Centers for Youth & Families  
1483 Tremont Street  
Boston, MA 02120  
Attention: Roberta Smalls/Yvette Martinez  
(617) 961-6952

**INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL NOT BE ACCEPTED.**  
Enrollment will remain open until Friday, April 24, 2026 or until all slots are filled.

Please include a photo of the camper you are applying for along with the completed application.

Enclosed medical section and camper immunization form must be completed.

*"This camp complies with regulations of the MA Department of Public Health and is licensed by the local board of health."*





## CAMP JOY SUMMER 2026 CAMPER APPLICATION

### CAMPER INFORMATION:

Camper's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: ☐ Male ☐ Female

Home Address: \_\_\_\_\_

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

Camper's Home Language: \_\_\_\_\_ Race (for State report only): \_\_\_\_\_

Camper's T-shirt size: Child ☐ S ☐ M ☐ L Adult ☐ S ☐ M ☐ L ☐ XL

### BUS PICK- UP/DROP- OFF MUST BE THE SAME ADDRESS (an adult must be present):

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

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

**\*\*NO ADDRESS CHANGES WILL BE ACCEPTED AFTER FRIDAY, MAY 8, 2026.  
AN ADULT MUST BE PRESENT AT PICK-UP/DROP-OFF LOCATION**

Name of Parent/Legal Guardian: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

### EMERGENCY CONTACTS (must be someone besides the parent/guardian):

**In case of emergency if parent/guardian is unavailable, please contact:**

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

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

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

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

## BCYF Camp Joy 2026

Camper's Name: \_\_\_\_\_

### **EMERGENCY CONSENT AND RELEASE**

If a situation arises in which my child is in need of prompt medical attention and I, or my designee (emergency contact), cannot be contacted, I hereby grant permission to a responsible member of the Camp Joy staff to authorize treatment for my child.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

### **ACKNOWLEDGEMENT**

The undersigned acknowledges that, in consideration of the opportunity to participate in the City of Boston's therapeutic recreation program, neither the City nor any of its employees are liable in the event of illness, injury, accident or death which may occur while my child or the participant is engaged in the program, is traveling to or from the program, or is engaged in any function of the program. This acknowledgment does not relieve the City or its employees from claims based on gross negligence, or intentional or reckless conduct.

The undersigned further acknowledges that if any child or the participant does not conform to the standards and organization of the program or if the directors of the program judge that the behavior of my child or the participant endangers himself/herself or the welfare of others in the program or the program itself, (s) he may be dismissed from the program upon written notice.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

### **PHOTOGRAPHIC RELEASE**

Please read and sign this photographic release. Please note that it is not necessary for you to sign this portion of the release for your child to attend Camp Joy. However, it would be to our convenience if you would sign this section.

I hereby give my consent to Camp Joy to photograph my son/daughter without limitation to use such pictures and/or stories in connection with any of the work of Camp Joy without consideration of any kind and I do hereby release Camp Joy and Boston Centers for Youth & Families from any claims whatsoever which may arise in said regard.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## BCYF Camp Joy 2026

Camper's Name: \_\_\_\_\_

### GENERAL INFORMATION:

Does your child use any of the following?

Glasses? ☐ Yes ☐ No    Hearing Aid? ☐ Yes ☐ No    Walker? ☐ Yes ☐ No

Does your child use any other type of adaptive equipment? ☐ Yes ☐ No    If yes, please explain: \_\_\_\_\_

Does your child have Allergies? ☐ Yes ☐ No    If yes, please explain: \_\_\_\_\_

Does your child have any dietary restriction? \_\_\_\_\_

Will it be necessary for your child to take medication during the camp day? ☐ Yes ☐ No

**\*\*If your child requires medication during camp hours you must complete the Authorization to Administer Medication to a Camper Form, and attend a mandatory orientation before the child can attend Camp Joy.**

Does your child have a sibling attending Camp Joy? ☐ Yes ☐ No    If so, what is his/her name? \_\_\_\_\_

What school does your child currently attend? \_\_\_\_\_

Does your child communicate verbally? ☐ Yes ☐ No \_\_\_\_\_

Does your child need assistance using the bathroom? \_\_\_\_\_

Does your child have a special toileting procedure? ☐ Yes ☐ No    If so please describe: \_\_\_\_\_

Did your child attend Camp Joy? ☐ Yes ☐ No \_\_\_\_\_

Please list any compulsive behaviors and appropriate responses for staff to take: \_\_\_\_\_

Please list any other precautions or behaviors that the camp staff should be aware of: \_\_\_\_\_

Can your child participate in physical activities? ☐ Yes ☐ No    If yes, list any necessary accommodations: \_\_\_\_\_

Does your child use a wheelchair? ☐ Yes ☐ No    If so, please identify the level of support needed: \_\_\_\_\_

## BCYF Camp Joy 2026

### Camper Application—Medical Section

**APPLICATION WILL NOT BE ACCEPTED WITHOUT THIS FORM COMPLETED**

Camper's Name: \_\_\_\_\_

Diagnosis: (Medical Term) \_\_\_\_\_

(Layman's Term) \_\_\_\_\_

Is camper subject to allergic reactions? ☐ Yes ☐ No If so, please specify: \_\_\_\_\_

Is camper medicated? ☐ Yes ☐ No

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time(s) administered: \_\_\_\_\_

How is medication administered? \_\_\_\_\_

Will it be necessary for camper to take medication during the camp day? ☐ Yes ☐ No

Is camper subject to seizures? ☐ Yes ☐ No Are they controlled? ☐ Yes ☐ No

To your knowledge, is the camper suffering from or has (s)he recently been exposed to any contagious disease?

Does camper have any dietary restrictions? \_\_\_\_\_

May camper participate in carefully supervised swimming activities? ☐ Yes ☐ No

May camper participate in a physical education program? ☐ Yes ☐ No

Are there any precautions that should be noted? (PLEASE SPECIFY) \_\_\_\_\_

Does camper live in a group home: \_\_\_\_\_

Camper's height: \_\_\_\_\_ Weight: \_\_\_\_\_

Does the camper use any other type of adaptive equipment? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Camper/Family Caseworker: \_\_\_\_\_

Agency: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Physical Examination \_\_\_\_/\_\_\_\_/\_\_\_\_

Print/Type Physician's Name \_\_\_\_\_

**BCYF Camp Joy 2026**  
**Authorization to Administer Medication to a Camper**  
(Completed by parent/guardian)

Camper and Parent/Guardian Information	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	
Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:
Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	
Medication Information 2	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:

Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	
<b>Authorization Information</b>	
<p>I hereby authorize the health care consultant or properly trained health care supervisor at _____          _____ (name of camp)          to administer, to my child, _____ the medication(s) listed above, in accordance with 105 CMR          _____ (name of camper)          430.160(C) and 105 CMR 430.160(D) [see below].</p>	
<p><b>If above listed medication includes epinephrine injection system:</b></p> <p>I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p>I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p>	
<p><b>If above listed medication includes insulin for diabetic management:</b></p> <p>I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p>	
Signature of Parent/Guardian:	Date:

**\*\* Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.



## 105 CMR 430 References

**105 CMR 430.160(A):** Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use. (M.G.L. c. 94C § 21).

**105 CMR 430.160(C):** Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

**105 CMR 430.160(D):** A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:

- (1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.
- (2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.
- (3) Document the circumstances in which a camper, Health Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:
  - a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:
    - 1) the camper is capable of self-administration; and
    - 2) the health care consultant and camper's parent/guardian have given written approval
  - (b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:
    - 1) the health care consultant and camper's parent/guardian have given written approval; d
    - 2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.
- (4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

**105 CMR 430.160(F):** The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

**105 CMR 430.160(I):** When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:

- (1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.
- (2) The medication disposal log shall be maintained for at least three years following the date of the last entry.

430.163:

**BCYF Camp Joy**  
**Parent's/Guardian's Permission to Apply Sunscreen to Child**

(Name of Child) \_\_\_\_\_

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) \_\_\_\_\_

to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ☐ I do not know of any allergies my child has to sunscreen.
  - ☐ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
  - ☐ I have provided the following brand/type of sunscreen for use on my child:
  - ☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body: \_\_\_\_\_
- \_\_\_\_\_

Parent/Guardian full name (print): \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



430.163:

**BCYF Camp Joy**  
**Parent's/Guardian's Insect Spray Permission Form**

We will be outside on our field trip and would like to have your permission to use insect repellent.

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

\_\_\_\_\_ I give permission for Camp Joy Staff to use insect repellent on my child.

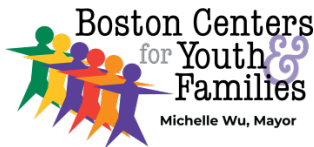
(OFF Insect Repellent, Family Care) \_\_\_\_\_

I have included my own brand of insect repellent to be used on my child.

The brand is: \_\_\_\_\_

\_\_\_\_\_ I DO NOT want any repellent used on my child.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## COVID-19

### BCYF Camp Joy Parents/Guardian Permission to Use Hand Sanitizer

I, Parent or Guardian of (Name of Child)

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give permission for **BCFY Camp Joy** to allow my child to use hand sanitizer with an alcohol content of sixty percent (60%) or more periodically throughout the camp day in addition to soap and water to clean his/her hands.

Hand sanitizer is always kept out of the reach of children. Children will be monitored closely with the use of hand sanitizer.

Parent/Guardian full name (print): \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_





Maura Healy  
Governor

Kim Driscoll  
Lieutenant Governor

The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
Bureau of Infectious Disease and Laboratory Sciences  
305 South Street, Jamaica Plain, MA 02130

Immunization Division

Tel: (617) 983-6800

Fax: (617) 983-6840

[www.mass.gov/dph/imm](http://www.mass.gov/dph/imm)

**To:** Camp Directors  
**From:** Pejman Talebian, MA, MPH, Director, Immunization Division  
**Date:** March 2023  
**Subject:** Required Immunizations for Children Attending Camp and Camp Staff

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Vaccination is critically important to control the spread of vaccine-preventable disease. In 2017, a single case of mumps at a summer camp in Massachusetts resulted in isolation of ill individuals, vaccination of those without evidence of two doses of MMR vaccine at several camps, and quarantine of those who did not have evidence of immunity to mumps and who could not get vaccinated. International staff and campers with missing or incomplete vaccination records made rapid implementation of disease control measures very challenging.

### Required Vaccines:

Minimum Standards for Recreational Camps for Children, 105 CMR 430.152, has been updated. Immunization requirements for children attending camp follow the Massachusetts school immunization requirements, as outlined in the [Massachusetts School Immunization Requirements](#) table, which reflects the newest requirement: meningococcal vaccine (MenACWY) for students entering grades 7 and 11 (on or after the 16<sup>th</sup> birthday, in the latter case; see the tables that follow for further details). Children should meet the immunization requirements for the grade they will enter in the school year following their camp session. Children attending camp who are not yet school aged should follow the Childcare/Preschool immunization requirements included on the School Immunization Requirements table.

Campers, staff and volunteers who are 18 years of age and older should follow the immunizations outlined in the document, [Adult Occupational Immunizations](#).

The following page includes portions of the Massachusetts School Immunization Requirements table and Adult Occupational Immunizations table relevant for camps.

If you have any questions about vaccines, immunization recommendations, or suspect or confirmed cases of disease, please contact the MDPH Immunization Program at 888-658-2850 or 617-983-6800. Address questions about enforcement with your legal counsel; enforcement of requirements is at the local level.

## Grades Kindergarten – 6

In ungraded classrooms, Kindergarten requirements apply to all students  $\geq 5$  years.

DTaP	<b>5 doses;</b> 4 doses are acceptable if the 4 <sup>th</sup> dose is given on or after the 4 <sup>th</sup> birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP.
Polio	<b>4 doses;</b> 4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday and $\geq 6$ months after the previous dose, or a 5 <sup>th</sup> dose is required. 3 doses are acceptable if the 3 <sup>rd</sup> dose is given on or after the 4 <sup>th</sup> birthday and $\geq 6$ months after the previous dose.
Hepatitis B	<b>3 doses;</b> laboratory evidence of immunity acceptable
MMR	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given $\geq 28$ days after dose 1; laboratory evidence of immunity acceptable
Varicella	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given $\geq 28$ days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

## Grades 7 – 12

In ungraded classrooms, Grade 7 requirements apply to all students  $\geq 12$  years.

Tdap	<b>1 dose;</b> and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at $\geq 7$ 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 or Tdap should be given if it has been $\geq 10$ years since Tdap.
Polio	<b>4 doses;</b> 4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday and $\geq 6$ months after the previous dose, or a 5 <sup>th</sup> dose is required. 3 doses are acceptable if the 3 <sup>rd</sup> dose is given on or after the 4 <sup>th</sup> birthday and $\geq 6$ months after the previous dose.
Hepatitis B	<b>3 doses;</b> laboratory evidence of immunity acceptable. 2 doses of Heplisav-B given on or after 18 years of age are acceptable.
MMR	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given $\geq 28$ days after first dose; laboratory evidence of immunity acceptable
Varicella	<b>2 doses;</b> first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given $\geq 28$ days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable
MenACWY (formerly MCV4)	<b>Grades 7: 1 dose;</b> MenACWY required. <b>Grades 11: 2 doses;</b> 2 <sup>nd</sup> dose MenACWY must be given on or after the 16th birthday and $\geq 8$ weeks after the previous dose. 1 dose is acceptable if it was given on or after the 16th birthday. Meningococcal B vaccine is not required and does not meet this requirement.

## Campers, staff and volunteers 18 years of age and older

MMR	<b>2 doses,</b> 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
Varicella	<b>2 doses,</b> 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
Tdap	<b>1 dose;</b> and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at $\geq 7$ 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 or Tdap should be given if it has been $\geq 10$ years since Tdap
Hepatitis B	<b>3 doses (or 2 doses of Heplisav-B) for staff whose responsibilities include first aid;</b> laboratory evidence of immunity is acceptable

\*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.

## Meningococcal Disease and Camp Attendees: Commonly Asked Questions

### ***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 Menveo) 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:

- 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);
- 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.
- not share food, drinks or eating utensils with other people, especially if they are ill.
- 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 Divisions of Epidemiology and Immunization at (617) 983-6800 or on the MDPH website at [www.mass.gov/dph](http://www.mass.gov/dph).

## **COMPLETED APPLICATION CHECKLIST**

**Before returning this BCYF Camp Joy Camper Application, please check (✓) to see that the following sections are FULLY completed:**

- ☐ CAMPER INFORMATION COMPLETED including HOME ADDRESS (you will get a transportation assignment)
- ☐ PARENT/GUARDIAN INFORMATION COMPLETED
- ☐ EMERGENCY CONTACT LISTED (AT LEAST ONE)— Must be different from home telephone number.
- ☐ EMERGENCY CONSENT SIGNED (parent/guardian signature)
- ☐ ACKNOWLEDGEMENT SIGNED (parent/guardian signature)
- ☐ PHOTO RELEASE SIGNED (parent/guardian signature)
- ☐ GENERAL CAMPER INFORMATION PAGE COMPLETED
- ☐ CAMPER MEDICAL SECTION
- ☐ CAMPER IMMUNIZATION PRINTOUT



WITHOUT MEDICAL & IMMUNIZATION PRINTOUT YOUR APPLICATION WILL BE RETURNED. PLEASE DOUBLE CHECK!



COMPLETE AN AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER FORM BY A PARENT/GUARDIAN IF NECESSARY. *Required for children needing medication during the camp day, prescribed inhalers for asthma and/or Epipens.*

☐ **NON-REFUNDABLE FEE:** Personal Checks and Cash are not accepted. Please make **money orders** payable to the **Foundation for BCYF-Camp Joy**. FULL payment is due with the completed application.

- If you are a **parent paying the entire Camp Joy fee**, you will pay \$275 for your first child and an additional \$80 for each additional sibling. Siblings without special needs can attend Camp Joy between the ages of 3-7. Siblings with special needs can attend Camp Joy between the ages of 3-15.
- If you are a parent receiving a scholarship from another agency or organization that will go towards covering a portion of the Camp Joy fee, you are responsible for paying the remaining balance of the \$350.00 fee. **Your application must include the payment or a letter stating intent to pay from the organization, as well as a money order from the parent for the remaining balance.** (For example, if you receive an agency scholarship for \$100, you are required to pay the remaining balance of \$250.)
- If you are an agency supporting in registering a child and covering the ENTIRE Camp Joy fee you are required to pay \$350. Documentation stating the agency's intention to pay
- and/or complete payment needs to accompany any application. \*\*\*Please DO NOT send a check that does not include information about whose fee the payment is intended to cover.

☐ **CAMPER PHOTO:** Please include a photo of camper along with Camper application!

☐ **CURRENT IEP (Individual Education Plan):** Please send copies of the goals pages of your child's most current IEP. A letter from your child's doctor will be accepted if you do not have an IEP.

**PERSONAL CHECKS AND CASH ARE NOT ACCEPTED. NO EXCEPTIONS!**  
**ONLY COMPLETED APPLICATIONS WILL BE PROCESSED!**



