CITY OF WALTHAM

BOARD OF HEALTH

MICHELLE M. FEELEY
DIRECTOR OF PUBLIC HEALTH

YEAR _____

RECREATIONAL CAMPS, OVERNIGHT CAMPS OR CABINS, MOTELS AND TRAILER CAMPS

Name of Camp and Federal ID Number: _____

Camp address and phone number: _____

Camp owner name and phone number: _____

CAMP CONTACT PERSON NAME, PHONE NUMBER and EMAIL (for use by Local and State Health Dept.)

PREFFERED MAILING NAME AND ADDRESS

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1. Type of Camp: DAY_____ OVERNIGHT_____
2. Land area of camp: _____
3. Opening Day: _____
4. Closing Day: _____
5. Number of persons to be accommodated per DAY _____ WEEK_____ SEASON _____
6. Number of Physically Handicapped to be accommodated DAY _____ WEEK_____ SEASON _____
7. Water Supply – Source: _____
8. Sewage Disposal Method: _____
9. Number of toilet facilities available – MALE _____ FEMALE _____
10. Lavatories available: _____
11. Refuse storage method: _____
12. Refuse disposal method: _____
13. Swimming pool available: _____
14. Food prepared on location: _____
15. Milk supply source: _____
16. Number of medical personnel: _____ Health Care Consultant name and title: _____
17. Health Care Consultant Massachusetts Professional License / Registration Number: _____
18. If this is an original application, attach plan of all buildings, structures, fixtures and facilities.
19. Medical records are required (physicals) of all campers and staff prior to attendance or employment, Said records to be current within (18) months of attendance or employment.

Fee: $165.00 PAYABLE TO THE CITY OF WALTHAM

119 School Street – Waltham, MA 02451 – Phone 781-314-3305 – Fax 781-314-3319