



CAMP QUESTIONNAIRE

Name of organization: _____

Camp name and location: _____

Website address (URL): www. _____

1. Number of days the camp is open per year: _____

2. Average number of campers per day: _____

3. Number of campers in each age range: _____ under 12 _____ age 13 - 16 _____ over age 16

4. Total number of: _____ adult counselors _____ youth counselors

5. What is the minimum age of the counselors? _____

6. Do adult counselors undergo criminal background checks? YES NO

7. What lifesaving skills are required of the counselors? CPR First Aid Other _____

8. Do you have a nurse on site? YES NO

9. What is the distance to the nearest emergency medical service? _____

10. Do you keep a medical history on file for each camper? YES NO

11. Are medications locked up? YES NO

12. Does your organization provide accident insurance for campers? YES NO

If yes,

a. Insurance company name: _____ Policy number: _____

Policy period: _____ Limits: _____

b. Accident insurance applies: to all campers is optional, at camper's expense

13. Is the camp leased to others? YES NO

If yes,

a. Are certificates of insurance obtained from all renters? YES NO

b. Are you named as additional insured on renter's policy? YES NO

14. Are there smoke detectors in all buildings? YES NO

15. Is drinking water provided by a private water source? YES NO

If yes, how often is the water supply tested? _____

16. What water supply is available for fighting fires? _____

Public Private Lake/Pool None Other _____

17. Is the camp located in a canyon or an area prone to brush fires? YES NO

18. Does a caretaker live at the camp during the off season? YES NO

19. Does the value of your outdoor equipment, including surfacing, exceed \$25,000? YES NO

If yes, value is \$ _____ **at** _____ **(location)**

If more than one location, attach a schedule of locations with value at each.

20. Indicate all applicable activities that occur at the camp:

Archery

Gymnastics

Trampoline

Boxing

Horseback riding

Water skiing

Climbing/Rappelling

Martial Arts (contact)

White water rafting

Downhill Skiing

Riflery

Wrestling

Swimming-Lake or beach

Rope Course: height _____

Boating/canoeing

Swimming-Pool (complete pool questionnaire)

Number of boats without motors: _____

Number of motorboats: _____

Describe supervision and safety control in place for any activities indicated above.

ABUSE COVERAGE:

21. Is abuse coverage desired? YES NO

If yes, complete questions 22-25

22. Type of abuse coverage currently in place:

- None
 Occurrence
 Claims Made
 Included in GL or Sublimit: _____
 Included in GL or Sublimit: _____

23. As respects abuse,

- a. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES NO
 b. Are you aware of any occurrences that could lead to a claim? YES NO

If yes to above, explain: _____

24. Describe any operational procedures you use to control the potential for abuse: _____

25. Does your facility have written policies that address abuse? YES NO
 a. Are policies reviewed with new employees and volunteers? YES NO
 b. Does policy require all clients be instructed to report possible incidents of abuse? YES NO
 c. Does policy require employees to formally report all incidents of potential abuse to the organization's director or board of directors? YES NO
 d. Does policy require known or suspected abuse incidents be reported to proper authorities? YES NO

26. Provide the following information:

	Employees	Volunteers
a. Total number with client contact?		
b. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. State 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal 10-digit fingerprint criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Federal 10-digit fingerprint criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. Are all controls indicated in e-h required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
j. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

Explain any "no" responses to question 26: _____

AUTO COVERAGE:

27. Does your organization own or lease vehicles? YES NO
 28. Are all owned or leased vehicles being submitted to us for coverage? YES NO
 If yes, attach Acord Auto applications.
 29. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
 a. More than 2 moving violations and/or accidents within a 3 year period YES NO
 b. Reckless driving, DUI or any felony driving conviction within a 5 year period YES NO

30. Is **hired auto liability** coverage desired? YES NO
If yes, does your annual vehicle rental expense exceed \$2,500? YES NO
If yes, what is your annual vehicle rental expense? _____
31. Is **non-owned auto liability** coverage desired? YES NO
If yes,
a. Total number of: _____ **employees** _____ **volunteers**
b. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization**.

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport members or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

PROFESSIONAL LIABILITY COVERAGE:

32. Is coverage desired for liability for health care services? YES NO
***This coverage is not available if you have employed medical doctors.**
33. Do you employ any medical doctors, psychiatrists, nurse practitioners or dentists? YES NO
If yes, how many are employed? _____
34. List the number of employed medical professionals: _____

Position	Full-time
RN	
LPN / CNA / Nurse Aides	
Therapists	

35. Of the professionals listed in question 33, do any carry their own professional liability insurance? YES NO
If yes, list all individuals and position: _____

36. Has any employed medical professional ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO
37. **As respects professional liability coverage**, is the agency aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your agency or any individual to be covered by this policy? YES NO

Explain any "yes" answers to questions 34-35 in this section:

38. Prior professional liability insurance carrier: _____
39. Type of professional liability: Claims Made Occurrence

Completed by: _____ Date completed: _____