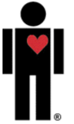
GREAT AMERICAN INSURANCE COMPANIES
Specialty Human Services Division
CAMP QUESTIONNAIRE



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

6. What lifesaving skills are required of the counselors? ☐CPR ☐First Aid ☐Other______________

7. Do you have a nurse on site? YES ☐ NO ☐

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

9. Are medications locked up? YES ☐ NO ☐

10. 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

11. Is the camp leased to others? YES ☐ NO ☐
    If yes, are certificates of insurance obtained from all renters? YES ☐ NO ☐

12. Are there smoke detectors in all buildings? YES ☐ NO ☐

13. Do you have commercial cooking equipment? YES ☐ NO ☐
    If yes, complete Commercial Cooking Questionnaire

14. Is drinking water provided by a private water source? YES ☐ NO ☐
    If yes, how often is the water supply tested?______________________________

15. What water supply is available for fighting fires?
    ☐ Public ☐ Private ☐ Lake/Pool ☐ None ☐ Other_______________

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

17. Does a caretaker live at the camp during the off-season? YES ☐ NO ☐

18. Indicate all applicable activities that occur at the camp.

☐Archery
☐Boxing/Martial Arts -Contact
☐Boxing/Martial Arts -Non-Contact
☐Climbing/Rappelling
☐Climbing Wall/Rope Course
☐Downhill Skiing
☐Equine Activities
☐Gymnastics
☐Riflery
☐Trampoline
☐ Water skiing
☐ White water rafting
☐ Wrestling
☐Swimming-Lake or beach
☐Swimming Pool - complete Pool/Hot Tub/Sauna questionnaire
☐Boating/canoeing -number of boats without motors: _____ number of motorboats: _____

19. **As respects abuse:**
    a. Have any claims ever been filed or allegations ever 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, explain: ______________________________

20. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES ☐ NO ☐

21. Provide the following information:

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES ☐ NO ☐	YES ☐ NO ☐
b. Education verified?	YES ☐ NO ☐	YES ☐ NO ☐
c. Personal references checked?	YES ☐ NO ☐	YES ☐ NO ☐
d. Written application required?	YES ☐ NO ☐	YES ☐ NO ☐
e. **State 10-digit fingerprint** criminal record check	YES ☐ NO ☐	YES ☐ NO ☐
f. Federal **1 0-digit fingerprint** criminal record check if in state less than 5 years	YES ☐ NO ☐	YES ☐ NO ☐
g. Federal **10-digit fingerprint** criminal record check regardless of time in state	YES ☐ NO ☐	YES ☐ NO ☐
h. Are all controls indicated in d-g required prior to any client contact?	YES ☐ NO ☐	YES ☐ NO ☐
I. How long are records kept documenting all screening activities outlined above?	_____ **years**	_____ **years**

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

22. Does your organization lease or rent vehicles short-term for the camp season? **YES** ☐ **NO** ☐
If **yes,** what is your annual vehicle rental expense? ____________

23. 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 ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Transport others			YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

24. Is coverage desired for liability for health care services? **YES** ☐ **NO** ☐

25. Do you employ any medical doctors, psychiatrists, nurse practictioners or dentists? **YES** ☐ **NO** ☐
This coverage is not available if you have employed medical doctors, dentists, psychiatrists or nurse practitioners.

26. List the number of employed medical professionals:

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

27. Of the professionals listed in question 26, do any carry their own professional liability insurance? **YES** ☐ **NO** ☐

28. Has any employed medical professional ever been reprimanded, refused admission or suspended by any association or administrative agency? **YES** ☐ **NO** ☐

29. **As respects professional liability coverage,** is your organization 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** ☐

Completed by:____ Date completed:__________

ADDITIONAL COMMENTS: