



Cradle Beach Camp
 8038 Old Lakeshore Road
 Angola, NY 14006
 (716) 549-6307 Ext. 206
 FAX: (716) 549-6825
 http://www.cradlebeach.org

2008 Respite Application

OFFICE USE ONLY

Date Received:	ISP: Yes No	Phy. Exam Date:	Weekend:	Evacuation	Verbal
Staff Initials:	NOD: Yes No	TB Test Date:		:Pub:	TA 1:1
				Y N	WC 1:1

How to Complete this Application:

All information requested in this application is to be *filled out completely even if the applicant is returning and you have submitted a completed application in the past*. In sections where information requested may not apply to you, check the N/A boxes. Completed applications are accepted on a first come, first serve basis. All applicants must be 10 years old or older and be developmentally disabled. They must live at home with family and NOT in a group home or other situation. Applicants must live in one of the seven counties of Western New York.

Applicant Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____ Sex: _____ Social Security #: _____

Race/Ethnicity (optional): African American Asian Caucasian Hispanic Other _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Telephone Number: _____

Height: _____ Weight: _____

Is the Applicant (circle one) New or Returning

Transportation:

ARRIVAL TIME: 7:00pm

DEPARTURE TIME: By 3:00pm

****CRADLE BEACH DOES NOT PROVIDE TRANSPORTATION FOR RESPITE WEEKEND****

Please check the Weekend you Prefer

Please put a #1 next to your 1st choice and a #2 next to your 2nd choice.

- | | | |
|-------------------------|---------------------------------|-----------------------------|
| ___ April 4 – April 6 | ___ May 16 – May 18 | ___ October 31 – November 2 |
| ___ April 25 – April 27 | ___ September 26 – September 28 | ___ November 7 – November 9 |
| ___ May 2 – May 4 | ___ October 17 – October 19 | |



Applicant Family Information:

Father/Male Guardian:

Name: _____

Address: _____

City/Zip Code: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Pager/Cell Phone: _____

E-mail Address: _____

Mother/Female Guardian:

Name: _____

Address: _____

City/Zip Code: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Pager/Cell Phone: _____

E-mail Address: _____

On a Respite Weekend, please provide where you can be reached if not at home:

Emergency Contact Information:

In case of emergency CBC will contact parents/guardians FIRST. If you cannot be reached, we will contact the people you list below. Please complete this entire section. Provide two (2) contact names (relatives, friends, etc.) ***other than yourself*** to contact in case of emergency. Please include their phone number and relationship to you.

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Agency Services: (Please make sure you **include all Case numbers**) [] N/A

Agency 1 Name: _____ **Case Number:** _____

Case Manager: _____ **Telephone:** _____

Agency 2 Name: _____ **Case Number:** _____

Case Manager: _____ **Telephone:** _____

Case Name (Guardian/Parent) _____



Health Insurance Information:

PLEASE NOTE: *Fill out completely.* We need all of the insurance information requested below, as well as a copy of a current insurance card for the camper. If this section is not completed, it will be returned to you causing delays in processing your application.

Health Insurance Company: _____

Name of Policy Holder: _____ Policy Number: _____

Group Number or Other Number: _____

Medicare #: _____ [] N/A MEDICAID #: _____ [] N/A

Physician / Medical Information:

Please Note:

Every applicant must have had a complete physical dated within at least one (1) year prior to the date they plan to attend a Respite Weekend. Please have your physician fill out the attached physical and over the counter form *and sign and date the forms.* Until we receive the physical and over the counter form, applicants will be placed on a pending list. ANY MEDICATION CHANGES AFTER PHYSICAL EXAM DATE MUST BE ACCOMPANIED BY A CURRENT WRITTEN PRESCRIPTION FROM THE APPLICANT'S PHYSICIAN.

Name of Physician: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Date of Last Physical: _____

Has the child been hospitalized within the past three (3) years? _____ Yes _____ No

If yes, please explain in detail below:



Present Medications:

(Please include all medications, include inhalers with frequency and/or nebulizer treatments) ANY MEDICATIONS CHANGES AFTER PHYSICAL EXAM DATE MUST BE ACCOMPANIED BY A CURRENT WRITTEN PRESCRIPTION FROM THE APPLICANT'S PHYSICIAN.

Medication	Dosage	Times Given	Route	Reason	PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION

Is the applicant a Hepatitis carrier? _____ Hepatitis Immunization? _____ Date _____

Date of last Tetanus Shot: _____

Parent/Guardian Medical Disclaimer/Agreement

(must be signed for child to attend Respite)

The doctors and nurses at Respite may give my child routine medications and over the counter medications, monitor health status and provide first aid and routine care. If there is any change in my child's care or his/her medical status, I wish to be notified.

If emergency treatment is necessary, **I give permission for my child to be brought to the nearest emergency room available** by ambulance or staff car for treatment. I authorize staff to release all records necessary for insurance purposes so that my insurance company can be billed for the visit, lab tests, and/or x-rays if necessary. However, **if time and circumstances permit, I would prefer that my child be taken to the following medical facility:** _____.

I will provide all necessary medications and supplies needed by my child for 3 days. However, if my child requires any additional prescription medication, I give the medical staff permission to obtain and bill me for this medication/supply after my notification. We will bill you directly if there is no medical insurance.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

(If this form is not signed, it will be returned to you for your signature, causing delays in processing the application)



Disability Information: [] N/A

(Please fill out completely and check all that apply)

[] Cerebral Palsy

[] Epilepsy

[] Down Syndrome

[] Spina Bifida

[] Mental Retardation (please specify individual conditions below)

[] Autism (please specify individual types/conditions below)

[] Hearing Disabilities (check all that apply below)

[] Total Hearing Loss [] Partial Hearing Loss [] Requires Hearing Aids

[] Vision Disabilities (check all that apply below)

[] Blind [] Visually Impaired [] Glasses [] Contact Lenses

[] Seizures (please provide detailed information below)

Type of Seizure: _____

Date of Last Seizure: _____

[] Ambulatory Disabilities

[] Awkward Gait [] Uses Walker [] Crutches [] Walks with Assistance
[] Braces [] Manual Wheelchair [] Electric Wheelchair

[] Communication Skills

[] Recognizes own name [] Responds to directions
[] Speech is easily understood [] Uses Gestures, Sign Language
[] Limited abilities, but can communicate daily needs
[] Comprehends normal conversation
[] Uses communication device (please send device with applicant to camp)



Sleeping Needs / Information: [] N/A

[] Walks in sleep [] **REQUIRES BED RAILS** [] Awakens during the night

Reason for Bed Rails:

Problems at bedtime: (please describe)

Toileting Issues / Information: [] N/A

[] Toilet Trained [] Wears Diapers (___at night ___all day) [] Is bowel care needed?

[] Bring to the bathroom ___ times a day **OR** other: _____

[] Wets bed (how often? _____)

[] Requires catheter every _____ hours **OR** other: _____

Comments:

Applicant ADL Skills: [] N/A

	Independent	With Prompts	With Partial Assistance	With Total Assistance
Showering				
Teeth Care				
Hair Care				
Dressing				
Shaving				
Menstruation Care				

Comments:



Allergy Information: [] N/A

General Allergies:

[] Pet or Animal Allergies (please specify): _____

Reaction: _____ Treatment: _____

[] Insect Allergies (please specify): _____

Reaction: _____ Treatment: _____

[] Dust / Mold / Pollen (please specify): _____

Reaction: _____ Treatment: _____

[] Other (please specify): _____

Reaction: _____ Treatment: _____

Allergies to Medications and Medical-Related Allergies:

[] Allergies to Medications (please list all below):

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

[] Latex Allergy

Reaction: _____ Treatment: _____

[] Other (please specify): _____

Reaction: _____ Treatment: _____

Allergies to Food:

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____



Food/Dietary Concerns: N/A

Please check inside all boxes as to your child's eating habits / needs.

Eating	Independent	Needs Help	Dependent	Eating	Independent	Needs Help	Dependent
Feeds Self				Drinks			
Cuts Food				Cleans Self			
Pours Drink				Other			

Diet:

- Regular Diabetic Calorie Restricted Ground
 Cut Up Low Sodium Pureed Sensitive to dairy
 Other _____

Needs help with positioning during meals

Uses adaptive feeding equipment:

(If adaptive equipment is required, please label with child's name and send to camp)

spoon fork cup plate other: _____

Check any eating difficulties:

- Drooling Gagging Sucking Bite reflex Chewing
 Choking Swallowing Eats slowly Unable to close mouth

Other: (please describe how to best assist this child during eating): _____



Behavioral Issues / Needs:

What type of things upset the child? _____

How does he/she express anger/frustration? _____

Adaptive Behavior (please check each behavior the child displays): [] N/A

- | | | |
|---|---|---|
| <input type="checkbox"/> Non-compliant | <input type="checkbox"/> Wanders/runs away | <input type="checkbox"/> Hits/Kicks others |
| <input type="checkbox"/> Bites | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Self injurious behaviors |
| <input type="checkbox"/> Eats inedibles | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> Inappropriate language |

Please comment on all items checked: _____

What is recommended to manage behavior? _____

Other important information: _____

What are the child's likes and dislikes? _____

***If the child is on a behavior plan, it needs to be explained to us so we can utilize this same approach. (attach to application)**

Respite Applicant will not be accepted unless following paperwork accompanies completed application:

- A completed physical dated within at least one (1) year prior to the date they plan to attend a Respite Weekend.
- Applicant must be tested for TB, within at least one (1) year prior to the Respite Weekend they plan to attend, and results proven to be negative and sent to camp for our records.
- It is necessary that all Respite applicants have a documented developmental disability (Notice of Decision from OMRDD). You or your Case Manager must submit such documentation with a first time application. This information is needed to process the application.
- ISP or ISP Addendum listing Cradle Beach as Respite Care Provider.

Please read the following statements and sign at the bottom of the page:

- I give permission for {Agency/School} _____ to furnish information about me and my family, which the agency/school decides will help respite better, serve us. This information will be shared with the Cradle Beach Camp Respite staff only.
- I give permission for the Respite Nurse to administer the prescription drugs, which I will send in the original container with the original label.
- I give permission for the Respite nurse to carry out the medical protocol of the Camp's Standing Orders on my child, as it pertains to non-emergencies and over the counter medications.
- I release any and all claims for injuries suffered or sustained by my son/daughter in going to or coming from Respite or while at camp and consent to hospital or medical care if needed.

Cradle Beach Camp may use my child's name, photograph, and video for publicity purposes. [] Yes [] No

Completed by (print name): _____

Signature: _____ Date: _____

Relationship to applicant: _____

(If this form is not signed, it will be returned to you for your signature, causing delays in processing the application)

Please return your completed application to:

**Cradle Beach Camp
Attn: Bonnie A. Brusk
8038 Old Lakeshore Road
Angola, New York 14006
549-6307, ext. 206**