

Thank You for your interest in Cradle Beach!

The application includes the inserts that also need to be completed.

Please Note:

Please do not worry about the summer food form. As of right now we do not need parents to fill out this form. If your child receives free and reduced lunches please provide us with the letter you received from your child's school stating that he/she receives free or reduced lunches.

Don't Forget:

You will need to submit proof of income, a copy of your child's health insurance card, \$30 non-refundable application fee along with your application, parent rating scale, and emergency contact form. We need all parts of the application filled out before we can accept your child.

The physical form and teacher form can be mailed in at a later time. Please do not wait for these forms to be completed when you send in your application.

We look forward to seeing your child this summer

If you have any questions please feel free to contact Robin Gould, Admissions Coordinator at 716-549-6307x 205 or admissions@cradlebeach.org



****NEW THIS YEAR****

This year we have one our staff members located in a buffalo office available to assist you with the application process. If you need any help filling out the application please contact Nick Schifano to set up a time to meet with him.

You may also call our admissions office for any questions that you may have while filling out the application.

Nick Schifano

Cradle Beach Project Soar Coordinator/ Community Outreach

Phone # (607) 437-6547

Office Address: 617 Main St, Buffalo, NY

Office Hours: Every Monday 11- 4 or by appointment

Email: nschifano@cradlebeach.org

Robin Gould

Admissions Coordinator

Cradle Beach

8038 Old Lake Shore Rd

Angola, NY 14006

(716) 549-6307 x 205

admissions@cradlebeach.org



How to Complete the Camper/PC Application:

General directions:

- **Please submit completed application As Soon As Possible as our sessions fill up quickly. Completed applications are accepted on a first come, first serve basis.**
- All information is to be **filled out completely even if the camper is returning.**
- All areas shaded in **gray** must have a signature. (The page will be returned to you if the signature is missing. This will delay your child being accepted.)
- All areas followed by “**!**” must be read carefully.
- All children must be between 8 - 16 years old at the start of their camping session.
- **We will not accept faxed applications.**
- **Additional applications are available online at www.cradlebeach.org.**

Payments:

- **All applications must include a non-refundable \$30.00 application fee in check, money order, or credit card.** The \$30 is deducted off the actual cost.
- Your acceptance letter and fee statement will be mailed **when your child is accepted.**
- No refund of camp fees will be given if child is sent home for behavioral problems.
- Cancellation refunds must be requested, in writing, two weeks prior to the start of camping session.

Additional Forms:

Information to be completed and submitted by the Parent or Guardian:

- 1) Completed Application Booklet (white)
- 2) **Emergency Contact Information (purple)**
- 3) Parent Rating Scale of Core Values (**blue**)
- 4) Summer Food Service Program (**pink**) **This form must be signed even if you do not qualify**
- 5) \$30 Application Fee
- 6) Copy of proof of income (W-2, current federal tax return, pay stub, or county issued budget such as SSI or disability.)
- 7) Copy of health insurance card(s)

The following forms should be completed and returned:

**The Teacher or MD may send the forms directly to camp.*

- 8) Teacher Reference Form (**green**)
- 9) Physical & Over the Counter Medication Form (**yellow**)

PLEASE DO NOT HOLD UP MAILING YOUR APPLICATION IF TEACHER REFERENCE FORM AND PHYSICAL ARE NOT COMPLETED.

Please return your completed application to:

Cradle Beach
Attn: Admissions
8038 Old Lakeshore Road
Angola, New York 14006
(716) 549-6307, ext. 205



(1) Camper/PC Application

OFFICE USE ONLY
Date Received: _____
Placement: _____
of Years Attended: _____

Camper Information: Please print all information clearly

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

Age: _____ Date of Birth: _____ Male Female

Race (Optional): African American Asian Bi Racial Caucasian
 Hispanic Middle Eastern Native American

Child SSN #: _____

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

County: _____ Telephone Number: (____) _____

Child resides with: _____ Relationship to child: _____
 (name of parent/guardian)

Is the Camper (circle one): **New** or **Returning** If returning, last year attended _____

Session Preference

Please choose which session you would prefer your child to attend.
 Use "1" for first choice and "2" for your second choice. **You must indicate a second choice.**
 Your child is placed based on availability. DO NOT assume your child is in the session you choose.

Camper		Special Needs Camper
___ 1 st Session: June 25 – July 3, 2012 (ages 8-11)		___ 1 st Session: June 25 – July 3, 2012 (ages 8-11)
___ 2 nd Session: July 6 – July 15 (ages 11-14)		___ 2 nd Session: July 6 – July 15 (ages 11-16)
___ 3 rd Session: July 18– July 27 (ages 8-11)	OR	___ 3 rd Session: July 18– July 27 (ages 8-11)
___ 4 th Session: July 31 – Aug. 9 (ages 11-14)		___ 4 th Session: July 31 – Aug. 9 (ages 11-16)
___ 5 th Session: Aug. 12 – Aug. 18 (ages 8-12)		___ 5 th Session: Aug. 12 – Aug. 18 (ages 8-16)

PC Camper (Ages 14-16, may choose any session).

___ 1st Session: June 25 – July 3 ___ 2nd Session: July 6 – July 15 ___ 3rd Session: July 18– July 27
 ___ 4th Session: July 31 – Aug. 9 ___ 5th Session: Aug. 12 – Aug. 18

Transportation:

ARRIVAL: ___ I will drive my child to camp in Angola, NY
 ___ I will drive my child to the Stanley Makowski School in Buffalo, NY to ride the camp bus
 [] My child will require a wheelchair bus
 [] My child will require a one-on-one aide on the bus

DEPARTURE: ___ I will pick my child up from camp in Angola, NY
 ___ I will pick my child up from the Stanley Makowski School in Buffalo, NY
 [] My child will require a wheelchair bus
 [] My child will require a one-on-one aide on the bus

How did you originally hear about Cradle Beach? (Please be specific)

- Radio _____
 School _____
 Other _____
 TV _____
 Community Center _____
 Newspaper _____
 Friend / Family _____
 Agency _____

Parent/Guardian 1:

Name: _____
 Address: _____
 City/Zip Code: _____
 Home Phone: (_____) _____
 Pager/Cell Phone:(_____) _____
 Employer: _____
 Work Phone: (_____) _____
 E-mail Address: _____

Parent/Guardian 2:

If address is the same as guardian # 1, please write "same"

Name: _____
 Address: _____
 City/Zip Code: _____
 Home Phone: (_____) _____
 Pager/Cell Phone:(_____) _____
 Employer: _____
 Work Phone: (_____) _____
 E-mail Address: _____

**** Would you prefer us to email the invoice and acceptance information? Yes No**
If YES, which email would you prefer us to send the information to _____

Other Household Members: Please list ALL other household members.

Name	Age	Attending Camp	Relationship
_____	_____	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	_____

Total number of people in your household: _____

Guardian/Legal Issues:

Who has custody or legal guardianship? _____

Are there any custodial issues? _____

Total Household Income:

You must send a copy of proof of income.

This includes W-2, tax return (must include adjusted gross income), paystub or county issued budget such as proof of disability or an SSI statement.

Agency Services: Does Not Apply

→ Please make sure you **include all case numbers.**

→ If Erie County Department of Social Services is your agency please verify Case Number with your Case Worker.

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

Service Coordinator/Case Manager: _____ **Telephone:** (____) _____

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

Service Coordinator/ Case Manager: _____ **Telephone:** (____) _____

Case Name (Guardian/Parent) _____

Family Assistance Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No	Foster Care: <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive Food Stamps: <input type="checkbox"/> Yes <input type="checkbox"/> No
CIN # _____	Case # _____

Education/School Programming:

School District: _____

School Name: _____

City: _____ **State:** _____ **Zip:** _____

Grade Just Completed: _____ **Classroom Type:** _____

Health Insurance Information:

! My child:
• does not have health insurance

has health insurance

YOU MUST SEND A COPY OF A CURRENT INSURANCE CARD

Physician / Medical Information:

Name of Physician: _____

Physician's Address: _____

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

Most recent or pending date of physical: _____

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

If yes, please explain in detail with date(s):

→ Your child must have a completed physical dated **one (1) year prior to the date** they plan to attend camp. The date on the **physical form must cover the entire session the child attends camp.**

→ Your physician must fill out **both** the attached physical and the over the counter medication form and **sign and date the forms.**

! Any medication changes after the physical exam date must be accompanied by a current
• written prescription from the camper's physician.

Present Medications:

! Please include all medications, include inhalers with frequency and/or nebulizer treatments.

Medication	Dosage	Times Given	Route	<u>Reason</u>	PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION

Parent/Guardian Medical Disclaimer/Agreement

*****Must be signed for child to attend camp*****

The doctors and nurses at camp 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.

→ **If time and circumstances permit, I would prefer that my child be taken to either medical facilities Childrens Hospital (WCHOB) or Lakeshore Hospital:** _____.

I will provide all necessary medications and supplies needed by my child for ten (10) 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.

In consideration of admission of this child to Cradle Beach, the undersigned hereby releases any and all claims for injuries suffered or sustained by the child in going to or coming from camp, or while at camp and consents to hospital or medical care if needed.

➡ 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 your camper's application****

Meningococcal Disease:

Information for College Students and Parents of Children at Residential Schools and Overnight Camps.

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshman living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as a result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshman living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10 – 15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?

The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease vaccination?

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org

MENINGOCOCCAL MENINGITIS VACCINATION DISCLAIMER

**** Must be signed for child to attend camp ****

New York State Public Health Law requires the operator of an overnight children’s camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Check one box

My child has received the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date received: _____

Note: The vaccine’s protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3 – 5 years

My child has not received the meningococcal meningitis immunization (Menomune™) I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. **I have decided that my child will not obtain** immunization against meningococcal meningitis disease.

➔ Parent/Guardian Signature: _____

➔ Print Name: _____ Date: _____

****If this form is not completed, it will be returned to you for your signature, causing delays in processing your camper’s application****

Allergy Information: Does Not Apply

General Allergies:

Dust / Mold / Pollen (please specify): _____

Reaction: _____ Treatment: _____

Insect Allergies (please specify): _____

Reaction: _____ Treatment: _____

Pet or Animal Allergies (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: _____

Sunscreen or PABA Allergy

Reaction: _____ Treatment: _____

Other (please specify): _____

Reaction: _____ Treatment: _____

Allergies to Food:

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Child's Interests / Needs:

What does the child like? _____

What does the child dislike? _____

What type of things upset the child? _____

How does he/she express anger/frustration? _____

What strategies are used to manage behavior? _____

What rewards work for good behavior? _____

Other important information: _____

Behavioral Issues: Does Not Apply

→ If the child has a behavior plan, it needs to be explained to us so we can utilize this same approach. Please attach to the application.

Adaptive Behavior (please check each behavior the child displays):

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

Please comment on all items checked: _____

Disability Information: **Does Not Apply** (Please fill out completely and check all that apply)

Epilepsy/ Seizures (please provide detailed information below)

Type of Seizure: _____ Date of Last Seizure: _____

ADHD

Asthma

Allergic rhinitis Exercise Induced Other _____

Autism (please check where your child is on the Autism Spectrum)

Autism Asperger Syndrome PDD-Nos Rett Syndrome

Cerebral Palsy

Deaf / Hearing

Partial Hearing Loss Total Hearing Loss Baha Implant
 Cochlear Implant Requires Hearing Aids

Down Syndrome

Learning Disabilities

Mental Retardation

Mental Health Issues (Must be diagnosed)

Anxiety Bi-polar Depression Mood Disorder OCD
 Phobia PTSD (Post- Traumatic Stress Disorder)
 Other _____

Neurological

Prader Willi Syndrome TBI Tourettes Tics
 Other _____

ODD

Spina Bifida

Vision Disabilities (check all that apply below)

Blind Glasses
 Legally Blind Contact Lenses
 Visually Impaired

Other _____

Ambulatory Abilities / Aids: Does Not Apply

- | | | | |
|---------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Awkward Gait | <input type="checkbox"/> Cane | <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Uses Walker |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Walks with Assistance |

Other: _____

Communication: Does Not Apply

- Speech is easily understood
- Comprehends normal conversation
- Recognizes own name
- Responds to directions
- Limited Abilities, but can communicate daily needs
- Uses Gestures
- Uses Sign Language
- Uses communication device (please send device with camper to camp)
- Other: _____

Assisted Daily Living Skills: Does Not Apply

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

Comments: _____

Food/Dietary Concerns: Does Not Apply

→ 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			

Special Diet: _____

Adaptive feeding equipment: Camp does have adaptive equipment to use. Please check off what your child would need

Spoon Fork Cup Plate other: _____

Child will be bringing his or her own equipment (please label with your child's name).

Eating Difficulties:

Bite reflex Choking Eats slowly Sucking Unable to close mouth

Chewing Drooling Gagging Swallowing

Needs help with positioning during meals (be specific) _____

Please describe how to best assist your child during eating:

Sleeping Needs / Information: Does Not Apply

- Walks in sleep Awakens during the night **Requires Bed Rails**

Reasons for Bed Rails: (please describe) _____

Problems at bedtime: (please describe) _____

Toileting Issues / Information: Does Not Apply

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

Wets bed (how often? _____)

Wears Diapers (___at night ___all day) Is bowel care needed?

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

! Swimming Information:

Is the child allowed to swim? Yes No Why? _____

Please describe any concerns, restrictions or adaptations regarding swimming:

Does the child have ear tubes? Yes (if yes, please send ear plugs) No

Additional Comments:

Is there anything else you would like a counselor, staying with your child 24 hours a day for the seven to ten days, to know? _____

Permission Page

****This page MUST be completed in order for your application to be processed****



Please check off appropriate box

Cradle Beach Camp may use my child's name, photograph, and video for publicity purposes.

Yes

No

My child **may** participate in the following activities:

Holidays

Birthdays

Please read the following statements.



*** I am aware of the following conditions:**

- **\$30.00 APPLICATION FEE IS NON-REFUNDABLE**
- **No refund of camp fees will be given if child is sent home for behavioral problems**
- **Cancellation refunds must be requested, in writing, from parents/guardians two weeks prior to child's arrival date.**
- **\$20.00 charge on all returned checks**

* I give my child permission to attend Cradle Beach. He/she can participate in all recreational and educational activities except those noted as restrictions.

* I have read, **agreed to, and signed the medical care disclaimer** as noted earlier in this application.

* I give Cradle Beach permission to contact my child's school or agency personnel to release information such as: Individual Education Plan, behavioral plans, ISP, NOD, etc.

* I authorize the release of any and all information to Cradle Beach Staff- specifically, any scripts for medication for my child.

* I agree not to send any money, valuables or electronic items (cds, IPODS, cell phone, etc.). I will not hold Cradle Beach accountable for any items.

* **I agree not to visit my child. Please notify us ahead of time of serious family emergency.**

* I agree to communicate with my child ONLY through letters or care packages.

* **Cradle Beach reserves the right to send a child home. This could be for behavioral reasons, endangerment to themselves or others, or we cannot guarantee their safety.**

➔ Completed by (print name): _____

➔ Signature: _____ Date: _____

➔ Relationship to applicant: _____



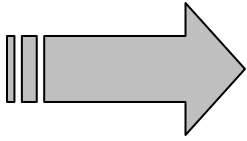
USE THIS AS A CHECKLIST FOR YOURSELF

Checklist of required documents:

- \$30 Application Fee (Check, Money Order , OR Credit Card)
**Please write child's first and last name on check or money order*
- All pages of the application booklet (WHITE) are filled out COMPLETELY
 - PAGE 6 Signature on Parent/Guardian Medical Disclaimer
 - PAGE 7 Signature on Meningococcal Meningitis Vaccination Disclaimer
(ONE BOX CHECKED EVEN IF YOUR CHILD IS NOT OLD ENOUGH)
 - PAGE 14 Signature and boxes checked on Permission Page
 - Proof of Income (Copy of one of the following W-2 forms, current paystubs, federal tax return, county issue budget)
 - Copy of Health Insurance Card
- EMERGENCY CONTACT FORM FILLED OUT (PURPLE FORM)
(In case of an emergency we will always contact parent/guardian FIRST.
If we cannot contact you, we will then call the emergency contacts you provided.
- Parent Rating Scale of Core Values (BLUE FORM)
- Summer Food Service Form (PINK FORM)
(MUST BE FILLED OUT AND SIGNED EVEN IF YOU DO NOT QUALIFY)

****INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED !****

Completed applications are based on first come first serve



**If you would like to pay your fee by credit card,
Please fill out this form and send it back to us.**

Thank You

CAMP FEE BY CREDIT CARD

Card Holder's Name: _____

Camper's Name: _____

Address: _____

City/ State/ Zip: _____

Telephone: (_____) _____

Credit Card: **VISA** **MASTER CARD**

Card # _____ - _____ - _____ - _____

Exp. Date: _____

Amount to be charged: \$ _____

Card Holder Signature: _____

<p><u>OFFICE ONLY</u></p> <p>Received By: _____</p> <p>Date: _____</p> <p>Camper Fee: \$ _____</p>



Office Use Only:

Session: _____ Unit: _____

Transportation: _____

Staff Initial: _____ Parent Initial: _____

(2) CRADLE BEACH EMERGENCY CONTACT INFORMATION

Camper's Name: _____ DOB: _____



In case of an emergency we will contact parents/ guardian FIRST

Parent/Guardian 1: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Parent/Guardian 2: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____



Two (2) emergency contacts in case we unable to reach you.

These must be persons who can also pick up your child.

Emergency Contact # 1 Name: _____

Relationship to Child: _____

Home # (____) _____ Cell # (____) _____

Work # (____) _____

Emergency Contact # 2 Name: _____

Relationship to Child: _____

Home # (____) _____ Cell # (____) _____

Work # (____) _____

CAMPER'S NAME _____ 20 _____



(8) TEACHER/ COUNSELOR REFERENCE FORM

This form may be mailed separately when completed by your child's teacher/ counselor.

TEACHER'S NAME: _____

TEACHER'S PHONE:_(_____)_____

SCHOOL / AGENCY:_____

CLASSROOM TYPE:_____

Mail completed form to:
Cradle Beach Admissions
8038 Old Lakeshore Rd
Angola, NY 14006

Dear Instructor:

*The above named child is applying to attend Cradle Beach Camp. Our campers stay overnight from 7-10 days. Please complete this **confidential form**, so our staff can assist the child to the best of our ability.*

Please return this form to the address above. Thank you in advance for helping this child have a great experience at camp.

Has the child spoken of past camp experiences? YES NO N/A
If yes, were these positive or negative comments?

Do you feel the child will do well in a camp setting with structured activities? *Please use examples.*

With unstructured time?

Does the child choose to be part of a group or individual activities?

What kinds of activities does the child have interest in?

What activities cause anxiety or stress?

(GREEN) PLEASE TURN OVER AND COMPLETE OTHER SIDE

CAMPER'S NAME _____

TEACHER REFERRAL FORM

Attach additional comments if necessary.

Are there any particular behaviors we should be aware of? *Please use examples.*

Does the child have any communication problems? *Please use examples.*

Any additional comments or suggestions that would help make the experience a positive one?

We have 3 cabin settings: Field, Hill, and Pioneer Camper (PC).
Field Campers: children with or without a disability, who have higher cognitive functioning or are independent in daily living skills. The counselor to camper ratio is 3:14.
Hill Campers: children who have a mental or physical disability, who might need total assistance or possible 1:1 supervision. The counselor to camper ratio is 8:10
Pioneer Campers (PC's): campers who are ages 14-16. Each PC is expected to have a positive attitude, a strong work ethic, and responsible behavior.
In your opinion, which type of accommodation would suit the child best?
<input type="checkbox"/> Field Cabin <input type="checkbox"/> Hill Cabin <input type="checkbox"/> PC Cabin 14-16 years old

Signature of person completing form: _____

Title: _____ Date: _____

CAMPER'S NAME : _____

DOB : _____



(9) PHYSICAL (Page 1)

(To be completed by your child's PHYSICIAN)

PHYSICIAN'S NAME _____

PHYSICIAN'S PHONE (_____) _____

PHYSICIAN'S ADDRESS _____

Mail or fax completed form to: Cradle Beach Admissions 8038 Old Lakeshore Rd Angola, NY 14006 (716) 549- 6825 (fax)

Your physician must complete the next three (3) pages.

The camper's physical exam must cover the entire time your child is at camp.

DIAGNOSIS (For confidential mental health diagnosis, please supply diagnostic code)	STATUS

ALLERGIES <input type="checkbox"/> DOES NOT APPLY	REACTION / TREATMENT

IMMUNIZATION (or supply copy of immunization record)	DATE/RESULT
HAEMOPHILUS INFLUENZA TYPE B	
DATE OF LAST TETANUS SHOT	
MMR	
HEP B SERIES	
POLIO	
CHICKEN POX / VARICELLA	
DPT	
MENINGOCOCCAL MENINGITIS	
TB TEST DATE	

Can this child go swimming? Yes No (Please note: campers who attend Respite, do not go swimming. Some of our campers who attend BOTH Respite and Summer Camp use the same physical for both programs.)

Seizures Yes No Type: _____ Last Episode: _____

Restrictions Yes No Describe: _____

Other orders or recommendations (include instructions for care of skin, bowel and catheterization)

CAMPER'S NAME _____ DOB _____

PHYSICAL EXAMINATION (Page 2) DATE OF EXAM _____

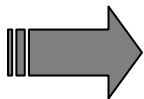
HT _____ WT _____ HR _____ BP _____ RR _____

System	Within Normal Limits	Abnormal	Reason
HEENT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMETIES			
NEURO			
SKIN			

C-Spine films are recommended for all children with Down Syndrome.
 Results: _____
 Results of other lab work (if needed): _____

Medication

Please list all medications the child is currently taking.



Any medication changes after exam date must be accompanied by a current written prescription from camper's physician.

Reasons must be given for each medication.

Medication	Dosage	Times Given	Route	Reason	Special instructions for administration of Meds

Physician Signature _____	Exam Date _____
Printed Name _____	License Number _____
Address _____	Phone () _____
City _____ State _____ Zip _____	Fax () _____

New York State public law has been amended to require that the following information be included on this camper application:
 1. Cradle Beach is required to be licensed by the New York State Dept. of Health. 2. Cradle Beach is required to be inspected twice yearly.
 3. Inspection reports concerning camp are on file at the Erie County Dept. of Health, Rath Building, Buffalo, NY

CAMPER'S NAME : _____
DOB : _____



OVER THE COUNTER MEDICATION FORM (Page 3)

YOUR PHYSICIAN MUST COMPLETE THIS FORM

Mail or fax completed form to:
Cradle Beach Admissions
8038 Old Lakeshore Rd
Angola, NY 14006
(716) 549- 6825 (fax)

Each medication must be marked either "yes" or "no"

- Yes No **Bactine** (topical) for minor wound care, first aid as needed
- Yes No **Triple Antibiotic Ointment** (topical) for wound healing
- Yes No **Tylenol** (oral) as directed on bottle for age/weight
- Yes No **Ibuprofen** (oral) as directed on bottle for age/weight
- Yes No **Chloraseptic Spray** for sore throat as needed
- Yes No **Cough Drops** for coughing, minor throat irritation as needed
- Yes No **Antacid Tablet** (oral) for stomach discomfort
- Yes No **Miralax** (oral) laxative as directed on bottle for age/weight
- Yes No **Benadryl** (oral) for swelling, hives, allergic reaction as directed on bottle for age/weight
- Yes No **Loratidine** (oral) for seasonal allergy symptoms, as directed on bottle for age/weight
- Yes No **Calamine Lotion or Cortaid** (topical) for insect bites/ bee stings
- Yes No **Visine/ Murine Plus Eye Drops** (topical in eye) for minor eye irritation
- Yes No **Sunscreen**
- Yes No **Insect/Bug Repellent**
- Yes No **Other** (please describe) _____

I hereby authorize that the following medications (checked yes) may be given to the above named child at Cradle Beach after nursing assessment.

Physician Signature: _____ Date: _____
Print Name: _____ License Number: _____
Address: _____ Phone: (____) _____
City: _____ State: _____ Zip: _____ Fax: (____) _____