

Dear Parent/ Guardian,

We are very honored to have you and your child as part of our Cradle Beach family. Thus, it is important that you complete the application and return it to us as soon as possible. Applications are processed on a first come, first served basis.

This download includes:

- **The 2010 Camper/PC Application**
- **Physical form to be completed by your child’s physician**
- **Teacher referral form to be completed by your child’s teacher**
- **Food Service Form**
- **Pre-parent rating scale**

To avoid delays please be sure to send in all the additional forms and copies needed to process the application. **A \$30 application fee must be included with the application. We only accept a Cradle Beach physical form filled out by your child’s physician.**

Below is our **fee scale**. To fit our families’ needs, we operate on a sliding fee scale and **offer a multi-child discount**. You **MUST** submit proof of income, either a W-2, 2009 tax return, county issued budget (such as SSI or disability, etc) or a most recent pay stub with year to date salary.

2010 CAMPER FEE SCALE						
INCOME		NUMBER OF PEOPLE IN THE HOUSEHOLD				
		TWO	THREE	FOUR	FIVE	SIX
0	14,999	100	100	100	100	100
15,000	19,999	120	100	100	100	100
20,000	24,999	160	130	100	100	100
25,000	29,999	200	165	135	100	100
30,000	34,999	240	220	200	180	160
35,000	39,999	315	295	275	255	235
40,000	44,999	360	340	320	300	280
45,000	49,999	405	385	365	345	325
50,000	54,999	450	430	410	390	370
55,000	59,999	495	475	455	435	415
60,000	64,999	540	520	500	480	460
65,000	69,999	585	565	545	525	505
70,000	74,999	630	610	590	570	550
75,000	79,999	635	615	595	575	555
80,000	84,999	640	630	620	610	600
85,000	89,999	680	670	660	650	640
90,000	94,999	720	710	700	690	680
95,000	99,999	760	750	740	730	720
100,000	up	800	790	780	770	760

PC FEE SCALE		
\$0	\$24,999	100
\$25,000	\$49,999	150
\$50,000	\$74,999	200
\$75,000	\$99,999	250
\$100,000	+	300

If you have any questions or concerns please call our Admissions Office at:

(716) 549-6307 ext. 205 or e-mail us at: admissions@cradlebeach.org

Thank you again for choosing Cradle Beach!

Sincerely,
 Robin Gould
 Molly McCarthy
 Admissions Coordinators

Summer Session Dates:

- Session 1: June 28 – July 7
- Session 2: July 10 – July 19
- Session 3: July 22 – July 30
- Session 4: Aug 3 – Aug 12
- Session 5: Aug 15 – Aug 21



How to Complete the 2010 Camper/PC Application:

General directions:

- All information requested in this application is to be **filled out completely even if the camper is returning and you have submitted a completed application in the past.**
 - All areas shaded in **gray** must be signed unless otherwise noted. If these sections are left blank the page will be returned to you causing delays in processing.
 - All areas followed by “!” indicate additional directions or information that must be read carefully.
 - In sections where information requested may not apply to you, check the “Does Not Apply” boxes.
 - Completed applications are accepted on a first come, first serve basis.
 - All applicants must be 8 years old on or before June 1st, 2010.
 - We do not accept faxed applications
- * NEW THIS YEAR—APPLICATIONS ARE AVAILABLE ONLINE ***

Payments:

- **All applications must include a non-refundable \$30.00 application fee.**
- Your acceptance letter and fee statement will be mailed **when your application is complete. All forms except teacher form and physical form must accompany application.**
- 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.

Additional Forms:

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

This information must be sent together in order to have your application processed.

- Application Packet
- Pre-Camp Parent Rating Scale **(blue)**
- Summer Food Service Program **(pink)** *This form needs to be signed even if you do not qualify*
- \$30 Non-refundable Application Fee
- Copy of proof of income (W-2, 2009 tax return, pay stub, or county issued budget such as SSI or disability, etc.)
- Copy of insurance card(s)

The following forms must be completed by the child's:

- Teacher: Teacher Referral Form **(green)**
- Physician: Physical & Over the Counter Medication Form **(yellow)**

The respective professional may send Cradle Beach the form directly.

Please return your completed application to:

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



2010 Camper/PC Application

OFFICE USE ONLY

Camper No.: _____

Placement: _____

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

___ 1st Session: June 28 – July 7 (ages 8-11)
 ___ 2nd Session: July 10 – July 19 (ages 12-14)
 ___ 3rd Session: July 22 – July 30 (ages 8-11)
 ___ 4th Session: Aug. 3 – Aug. 12 (ages 12-14)
 ___ 5th Session: Aug. 15 – Aug. 21 (ages 8-12)

OR

Special Needs Camper

___ 1st Session: June 28 – July 7 (ages 8-11)
 ___ 2nd Session: July 10 – July 19 (ages 12-16)
 ___ 3rd Session: July 22 – July 30 (ages 8-11)
 ___ 4th Session: Aug. 3 – Aug. 12 (ages 12-16)
 ___ 5th Session: Aug. 15 – Aug. 21 (ages 8-16)

PC Camper

Ages 14-16, may choose any session. See Pioneer Camper insert to learn more about our "PC program".

___ 1st Session: June 28 – July 7 ___ 2nd Session: July 10 – July 19 ___ 3rd Session: July 22 – July 30
 ___ 4th Session: Aug. 3 – Aug. 12 ___ 5th Session: Aug. 15 – Aug. 21

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 or 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 or 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 _____
 Billboard _____
 Agency _____

Male Guardian / Father / Foster Parent:

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

Female Guardian / Mother / Foster Parent:

If address is the same as male guardian, please write

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

Other Household Members: Please list ALL other household members so we may bill you appropriately.

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 concerns? _____

Who can pick up the child? _____

Total Household Income:

→ Please provide **total** household income **before deductions** for both parents/guardians:

! You must attach a copy of proof income (W-2, tax return, paystub or county issued budget such as proof of disability or an SSI statement) in order to have your application processed.

Fees are based on a sliding fee scale and will be noted in the camper's acceptance letter.

\$ _____ Weekly **or** \$ _____ Bi-Weekly **or** \$ _____ Monthly **or** \$ _____ Yearly

Emergency Contact Information:

→ In case of emergency Cradle Beach will contact parents/guardians **FIRST**. If you cannot be reached, we will contact the people you list below.

→ You must 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: _____ Phone: (____) _____ Relationship: _____

Name: _____ Phone: (____) _____ Relationship: _____

Education/School Programming:

School Name: _____

City: _____ State: _____ Zip: _____

Grade Just Completed: _____ Classroom Type: _____

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: Yes No

Child Welfare Services: Yes No

CIN # _____

Foster Care: Yes No

Receive Food Stamps: Yes No

Case # _____

Health Insurance Information:

PLEASE NOTE:

! We need all of the insurance information requested below, as well as a **copy of a current insurance card** for the camper.

→ If there is secondary coverage please supply us with that information.

→ If this section is not completed, it will cause delays in processing your camper's application.

Health Insurance Company: _____ Health Insurance Company: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Policy Number: _____ Policy Number: _____

Group Number or Other Number: _____ Group Number or Other Number: _____

Medicaid #: _____ **Medicare #:** _____

Does Not Apply

Does Not Apply

Physician / Medical Information: We will only accept Cradle Beach Physical forms

PLEASE NOTE:

→ Every applicant must have a complete 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.

→ Please have your physician 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.**

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):

Present Medications:

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

! If medication has changed by the time of the camp session, **a written prescription from the doctor must match the medication bottle** when brought to camp or your child will not be able to attend.

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 the following medical facility:** _____.

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 and sign below.

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

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 signed, 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)

<input type="checkbox"/> Epilepsy/ Seizures (please provide detailed information below) Type of Seizure: _____ Date of Last Seizure: _____

ADHD _____

Asthma _____

Autism (please specify individual types/conditions below)

Cerebral Palsy _____

Down Syndrome _____

Learning Disabilities _____

Mental Retardation (please specify individual conditions below)

Mental Health Issues (please specify individual conditions below)

Neurological _____

ODD _____

Spina Bifida _____

Hearing Disabilities (check all that apply below)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Total Hearing Loss | <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> Baha Implant |
| <input type="checkbox"/> Partial Hearing Loss | <input type="checkbox"/> Requires Hearing Aids | |

Vision Disabilities (check all that apply below)

- | | |
|--|---|
| <input type="checkbox"/> Blind | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Legally Blind | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Visually Impaired | |

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

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

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:

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

Spoon Fork Cup Plate other: _____

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

- 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: _____

! 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

! Please read the following statements.
Mark in the gray boxes appropriately.

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: *check those that apply*

Holidays

Birthdays

! Please read the following statements.
Sign and date in the gray box at the bottom of the page.

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 agree not to send any money, valuables or electronic items (cds, mP3 players, PSP's, **cell phone**, etc.). I will not hold Cradle Beach accountable for any items.

I agree not to visit my child at Cradle Beach and to communicate with my child by letter, unless a serious family matter makes this necessary.

- **\$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**

➔ Completed by (print name): _____

➔ Signature: _____ **Date:** _____

➔ Relationship to applicant: _____

****If this page is not signed, it will be returned to you for your signature, causing delays in processing your camper's application****

CAMPER'S NAME: _____

DATE OF BIRTH: _____



PHYSICAL

To be completed by your child's MEDICAL DOCTOR.

This form may be mailed separately from your application.

We will only accept this form for your child's physical.

Do not wait for this form to mail in your application.

Mail completed form to:
Cradle Beach Admissions
8038 Old Lakeshore Rd
Angola, NY 14006
(716) 549- 6307 ext. 205

PHYSICIAN'S NAME _____

PHYSICIAN'S PHONE (_____) _____

PHYSICIAN'S ADDRESS _____

Your medical doctor must complete the next three (3) pages. **The camper's physical exam must be dated no more than one (1) year from the end date of your child's 2010 session.**

DIAGNOSIS <small>For confidential mental health diagnosis, please supply diagnostic code</small>	STATUS

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

IMMUNIZATION	DATE/RESULT
HAEMOPHILUS INFLUENZA TYPE B	
DATE OF LAST TETANUS SHOT	
TB TEST DATE	
MMR	
HEP B SERIES	
POLIO	
CHICKEN POX / VARICELLA	
DPT	
<input type="checkbox"/> WE HAVE FULFILLED THE REQUIREMENTS FOR THE MENINGOCOCCAL MENINGITIS VACCINATION (MD INITIAL) _____	

MD INITIAL _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE



(YELLOW)

CAMPER'S NAME _____ DATE OF BIRTH _____

PHYSICAL EXAMINATION

DATE OF EXAM _____

HT _____ WT _____ HR _____ BP _____ RR _____

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEENT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
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 MED

Can this child go swimming? Yes No

Seizures Yes No Type: _____ Last Episode: _____

Restrictions Yes No Describe: _____

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

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 _____

DATE OF BIRTH _____



Mail completed form to:
Cradle Beach Admissions
8038 Old Lakeshore Rd
Angola, NY 14006
(716) 549- 6307 ext. 205

OVER THE COUNTER MEDICATION FORM

YOUR MEDICAL DOCTOR MUST COMPLETE THIS FORM

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

PHYSICIAN CONSENT

Physician Signature: _____ Date: _____

Printed Name: _____ License Number: _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ Fax: (____) _____

(YELLOW)



PRE – CAMP PARENT RATING SCALE

Dear Parent/Guardian:

***This form is required with your completed application for ALL campers.** This sheet contains a list of 19 development assets that are helpful in assisting children to mature into healthy, caring and responsible adults. During your child's stay at camp, our counselors will spend time working with him/her on each of the following:*

Community/Interpersonal Relations:

- Adults in the child's life model positive, responsible behavior
- Child's best friends model responsible behavior
- Adults in the child's life express high expectations
- Child has compassion, sensitivity, and friendship skills
- Child tries to solve problems without fighting
- Child can say no to negative peer pressure and dangerous situations
- Child knows of and is comfortable with people of different cultural/racial/ethnic backgrounds
- Child actively participates in weekly lessons or practice of music, theater, or the arts

Personal Character Values:

- Child feels proud about helping other people
- Child can stand up for his or her beliefs
- Child can tell the truth even when it is not easy
- Child accepts and takes personal responsibility
- Child believes it's important not to be sexually active or to use alcohol or drugs
- Child knows how to plan ahead and make choices
- Child wants to do well

Identify of Self

- Child feels that he or she has control over what happens to them
- Child has confidence and feels good about himself or herself
- Child expresses that "my life has a purpose"
- Child is positive about his or her personal future

In an effort to make your child's camping experience as rewarding as possible, please help us to get to know your child by filling out the chart on the reverse side of this paper.

Thank you for your time and cooperation.

PLEASE TURN OVER AND COMPLETE OTHER SIDE

(BLUE)



CAMPER'S NAME: _____

Please indicate below where you believe your child is currently is in each area by placing a ✓ in the appropriate box.

Pre – Camp Parent Rating Scale

	Always	Often	Sometimes	Never	Don't Know
Adults in child's life model positive, responsible behavior					
Child's best friends model responsible behavior					
Adults in the child's life express high expectations					
Child has compassion, sensitivity, and friendship skills					
Child tries to solve problems without fighting					
Child can say no to negative peer pressure and dangerous situations					
Child knows of and is comfortable with people of different cultural, racial, or ethnic backgrounds					
Child actively participates in weekly lessons or practice of music, theater, or the arts					
Child feels proud about helping other people					
Child can stand up for his or her beliefs					
Child can tell the truth even when it is not easy					
Child accepts and takes personal responsibility					
Child believes it's important not to be sexually active or to use alcohol or drugs					
Child knows how to plan ahead and make choices					
Child wants to do well					
Child feels that he or she has control over what happens to them					
Child has confidence and feels good about himself or herself					
Child expresses that "my life has a purpose"					
Child is positive about his or her personal future					

This form MUST be returned before your child can attend camp



TEACHER REFERENCE FORM

*Do not wait for this form when mailing in your application.
This form may be mailed separately when completed by your child's teacher.*

TEACHER'S NAME: _____

TEACHER'S PHONE:_(_____)_____

SCHOOL / AGENCY:_____

CLASSROOM TYPE:_____

Mail completed form to:

Cradle Beach Admissions
8038 Old Lakeshore Rd.
Angola, NY 14006
(716) 549-6307 ext. 205

Dear Instructor:

*The above named child is applying to attend Cradle Beach Camp. Our campers stay at camp from seven to ten days with approximately 12-15 campers per cabin. They are placed in cabins with campers who function at similar levels of achievement. Please accurately fill out this **confidential form**, so the staff can ensure the child will receive the appropriate attention that (s)he needs.*

*Please return to Cradle Beach Camp at the address above when completed. Attach additional sheets if necessary. Also, **please** be as specific as possible and use examples as needed. Thank you in advance for helping make camp a great experience for our campers!*

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 be as specific as possible.

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?

PLEASE TURN OVER AND COMPLETE OTHER SIDE



(GREEN)

CAMPER'S NAME _____

TEACHER REFERRAL FORM

Attach additional sheets if necessary.

What activities cause anxiety or stress?

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 2 cabin settings, Field cabins and Hill Cabins.

Field Cabins: are for children with or without a disability who are higher functioning or are independent in activities of daily living. The counselor to camper ratio is 3:14.

Hill Cabins: are for children who have a mental or physical disability and who might need total assistance or more 1:1 supervision. The counselor to camper ratio is 7:11

In your opinion, which type of accommodation would suit the child best?

Field Cabin Hill Cabin

SIGNATURE OF PERSON COMPLETING FORM: _____

PRINT NAME AND TITLE: _____

DATE: _____ PHONE & EXT: (_____) _____



Dear Parent/Guardian:

Children need healthy meals to learn. Cradle Beach offers healthy meals every day. Children from households that meet federal income guidelines (outlined below) are eligible for free meals or reduced price meals. To apply for free or reduced price meals, submit a Direct Certification letter from the NYS Office of Temporary and Disability Assistance **OR** complete the enclosed application, sign it, and return it to Cradle Beach as soon as possible. Please refer to the guidelines contained in this letter when completing the application. We cannot approve an application that is not complete, so be sure to fill out all required information.

- 1. Do I need to fill out an application for each child?** No. Complete the application to apply for free or reduced price meals. Do not fill out more than one application for your household.
- 2. Who can get free meals?** Children in households getting Food Stamps or TANF and most foster children can get free meals regardless of your income. Also, your children can get free meals if your household income is within the free limits on the Federal Income Guidelines. Each foster child must be listed on a separate application, with Part 2 completed and include an adult signature.
- 3. Can homeless, runaway and migrant children get free meals?** Please call Cradle Beach to see if your child(ren) qualify, if you have not been informed that they will get free meals.
- 4. Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application.
- 5. Should I fill out an application if I received a letter this year saying my children are approved for free or reduced price meals?** Please read the letter you received carefully and follow the instructions. Call Cradle Beach at (716) 549-6307 X 205 if you have questions.
- 6. I get WIC, can my child(ren) get free meals?** Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out an application.
- 7. Will the information I give be checked?** Cradle Beach may ask you at any time during the year to verify your eligibility. You will be notified, in writing, if you have been selected for Verification. Camp officials may ask you to send papers showing that your child should receive free or reduce price meals at the time you applied.
- 8. If I don't qualify now, may I apply later?** Yes. You may apply at any time during the year if your household size goes up, income goes down, or if you start getting Food Stamps, TANF or other benefits. If you lose your job, your children may be able to get free or reduced price meals.
- 9. What if I disagree with the decision about my application?** You should talk to Cradle Beach officials. You also may ask for a hearing by contacting Cradle Beach directly.
- 10. May I apply if someone in my household is not a U.S. citizen?** Yes. You or your child(ren) do not have to be a U.S. citizen to qualify for free or reduced price meals.
- 11. Who should I include as members of my household?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children who live with you.
- 12. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you get it only sometimes.

Income Chart: The following chart lists income levels according to household size and income levels received either yearly, monthly or weekly. If your total household income is the same or less than the amounts on the Income Chart below, your children may be eligible to receive free or reduced price meals.

REDUCED PRICE ELIGIBILITY INCOME CHART					
Effective from July 1, 2009 to June 30, 2010					
Household Size	Annual	Month	Twice-Monthly	Bi-Weekly	Weekly
1.....	\$20,036	\$1,670	\$ 835	\$ 771	\$ 386
2.....	26, 955	2, 247	1,124	1,037	519
3.....	33, 874	2, 823	1, 412	1,303	652
4.....	40, 793	3, 400	1, 700	1,569	785
5.....	47,712	3, 976	1, 988	1,836	918
6.....	54, 631	4, 553	2, 277	2, 102	1,051
7.....	61, 550	5, 130	2, 565	2, 368	1,184
8.....	68, 469	5, 706	2, 853	2,634	1,317
For each additional family member add.....	6, 919	577	289	267	134

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, submit a Direct Certification letter received from the Office of Temporary and Disability Assistance OR complete only one application for your household using the instructions. Sign the application and return the application to Cradle Beach. Please complete a separate application for **each** foster child. Call the school if you need help: (716) 549- 6307 x 205. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

- (1) Print the names of the children for whom you are applying on one application. (For Foster Children, see Part 2)
 - (2) List their grade and school.
-

PART 2 HOUSEHOLDS WITH A FOSTER CHILD SHOULD COMPLETE THIS PART AND SIGN PART 5. A foster child is the legal responsibility of a welfare agency or court. A separate application must be completed for each foster child.

- (1) List the foster child's monthly "personal use" income. ("Personal Use" income is money given by the welfare office identified by category for the child's personal use, such as an allowance, and all other money the child gets, such as money from his/her family or money from the child's employment.) Write "0" if the foster child does not get "personal use" income. SKIP PART 4. Do not list any other children, household members or income, or a social security number.
 - (2) A foster parent or other official representing the child must sign the application in PART 5.
-

PART 3 HOUSEHOLDS GETTING FOOD STAMPS, TANF OR FDPIR SHOULD COMPLETE THIS PART AND SIGN PART 5. COMPLETE A SEPARATE APPLICATION FOR A CHILD/CHILDREN WITH A DIFFERENT CASE NUMBER.

- (1) List a current Food Stamp case number, TANF or FDPIR (Food Distribution Program on Indian Reservations) number. Do not use the number on your benefit card. The case number is provided on your benefit letter.
 - (2) An adult household member must sign the application in PART 5. SKIP PART 4. Do not list names of household members or income if you list a food stamp case number, TANF or FDPIR number.
-

PARTS 4 & 5 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 5.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
 - (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, bi-weekly, monthly, 2 x per month.** Changes in income during the school year no longer need to be reported.
 - (3) The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
 - (4) The application must include the social security number of the adult who signs **PART 5** if Part 4 is completed. If the adult does not have a social security number, write "none". If you listed a food stamp, TANF or FDPIR number, or if you are applying for a foster child, a social security number is not needed.
-

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). In order to determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

PRIVACY ACT STATEMENT

Section 9 of the National School Lunch Act requires that unless your children's food stamp, TANF or FDPIR case number is provided, you must include the social security number of the adult household member signing the application, or indicate that the household member does not have a social security number. The disclosure of a social security number is voluntary. However, if a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or other benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

DISCRIMINATION COMPLAINTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, gender, or disability. To file a complaint, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY)*. USDA is an equal opportunity provider and employer.

COMPLETE ONLY ONE APPLICATION FOR YOUR HOUSEHOLD

____ F ____ R ____ D
 Temp Free Expires _____
 45 Days

FAMILY APPLICATION FOR FREE AND REDUCED PRICE SCHOOL MEALS/MILK

To apply for free and reduced price meals for your children, read the instructions on the back, complete only one form per household, sign your name and return it to _____ . Call _____ if you need help. For additional names, list on a sheet of paper.

1. CHILDREN IN SCHOOL: (Complete a separate application for each foster child or us the Single Child Application.)

Children's Names (Last, First, MI)	Grade/Teacher	School

2. FOSTER CHILD: If the above named child is the legal responsibility of a welfare agency or court, check this box.
 List the child's personal use income: _____ (Write "0" if the child has no personal use income.) Skip to Part 5.

3. HOUSEHOLDS GETTING FOOD STAMPS OR TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF): Complete this section and sign the application in Part 5 **OR** submit a Direct Certification letter from the Office of Temporary and Disability Assistance or Food Distribution Program on Indian Reservations (FDPIR). Complete a separate application for children with a different case number or no case number. Write your case number as provided on your benefit letter, **not the number on your benefit card.**
 Food Stamp Case #: _____ TANF/FDPIR Case #: _____

4. HOUSEHOLD MEMBERS & TOTAL HOUSEHOLD INCOME: If you did not give a food stamp or TANF case number, or submit a Direct Certification letter, complete this part and all of part 5.

Show how often each amount is received. See Examples	<u>CURRENT INCOME/PAY PERIOD</u>			
	Examples: \$100.29/weekly, \$100.29/bi-weekly, \$100.29/2x per month, \$100.29/monthly If pay period is not noted, the reviewing official will process the reported income amount as received WEEKLY.			
List the names of everyone in your household	Earnings From Work Before deductions	Child Support, Alimony, Etc.	Payments from Pension or Retirement	Other Income
	Amount / How Often	Amount / How Often	Amount / How Often	Amount / How Often
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
7. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

5. SIGNATURE: An adult household member **MUST** sign the application before it can be approved.
 I certify that all of the information is true and that all income is reported. I understand that the information is being given for the school to receive federal funds; that school officials may verify the information and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and federal laws, and my children may lose meal benefits.

SIGNATURE: _____ DATE: _____ SOCIAL SECURITY # _____ - _____ - _____

Home Telephone Work Telephone Mailing Address Zip Code

SOCIAL SECURITY NUMBER: If Part 4 is completed, the adult who signs the application must provide his/her Social Security number.

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

ANNUAL INCOME CONVERSION (ONLY CONVERT WHEN MULTIPLE FREQUENCIES ARE REPORTED ON APPLICATIONS): WEEKLY X 52; EVERY 2 WEEKS X 26; TWICE A MONTH X 24; MONTHLY X 12

FOOD STAMP, TANF, Foster Child
 INCOME HOUSEHOLD: Total Household Income/Frequency: _____ / _____ Household Size: _____
 Application APPROVED for: Free Meals Reduced Price Meals
 Temporary Free (expires in 45 days) ___/___/___ Application DENIED
 Date Notice Sent: _____ Signature of Reviewing Official: _____ Date: _____