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

OFFICE USE ONLY

Date Received: Staff Initials:	Agency to Bill:	Placement:	Camper No.:

FORMS		Staff Initials
Physical Date:	☐ Current / /	
Physical Comments:		
Food Form:	☐ Eligible ☐ Not Eligible	
Teacher Form:	☐ Received	
Parent-Rating Scale:	☐ Received	
Proof of Income:	☐ Received	
Income Comments:		
Insurance Card:	☐ Received	
Medical Waiver:	☐ Signed	
Meningitis Disclaimer:	☐ Signed	
Permission Page:	☐ Signed	
STAFF MEMBER ENTERING INTO COMPUTER:		

PAYMENTS	Fee: Paid In Full Date: ___________

Application Fee:	$__________.____	Check/MO #:_____________________________

Payment Options: ____

____

____

Additional Comments/Communications:

Date:

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:

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 "same"

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
_________________________	_______________	☐	__________________________
_________________________	_______________	☐	__________________________
_________________________	_______________	☐	__________________________
_________________________	_______________	☐	__________________________
_________________________	_______________	☐	__________________________
_________________________	_______________	☐	__________________________

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
Foster Care: ☐ Yes ☐ No
Child Welfare Services: ☐ Yes ☐ No
Receive Food Stamps: ☐ Yes ☐ No
CIN #___________________________________
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 #: ________________________________ ☐ Does Not Apply	**Medicare** #: ________________________________ ☐ 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	Reason	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****

New York State Department of Health
Bureau of Communicable Disease Control

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 DICLAIMER

*** 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):

☐ Bites	☐ Hits/Kicks others	☐ Non-compliant
☐ Destroys property	☐ Inappropriate language	☐ Self injurious behaviors
☐ Eats inedibles	☐ Inappropriate sexual behaviors	☐ 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** ____

☐ **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)
☐ Total Hearing Loss ☐ Cochlear Implant ☐ Baha Implant
☐ Partial Hearing Loss ☐ Requires Hearing Aids

Vision Disabilities (check all that apply below)
☐ Blind ☐ Glasses
☐ Legally Blind ☐ Contact Lenses
☐ Visually Impaired

Ambulatory Abilities / Aids: ☐ Does Not Apply

☐ Awkward Gait ☐ Cane ☐ Electric Wheelchair ☐ Uses Walker
☐ Braces ☐ Crutches ☐ Manual Wheelchair ☐ 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****