Camper / PC Application

Mail Application:
Cradle Beach Camp
Attention: Admissions
8038 Old Lakeshore Rd.
Angola, NY 14006

Camper Information: *Please print all information clearly*

Last Name:_____ First Name:_____ M.I.: _____

Mailing Address:_____ City: _____ State: _____

Zip code:_____ Telephone Number: (____) _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Grade Completing in 2018:_____ Is the Camper: ☐ New or ☐ Returning

School District: _____ School Name:_____

Parent Information: ***Parent child resides with***

Parent / Guardian 1:	***Parent / Guardian 2:***
Name:	Name:
Relationship to Camper:	Relationship to Camper:
Cell Phone:	Cell Phone:
Email Address:	Email Address:
Employer:	Employer:
Work Phone:	Work Phone:

Session Preference

Please indicate which 2 sessions you prefer according to your child's age. Your child will be placed in one of the two choices based on availability or which is best suited for your child needs. For children with Developmental Disabilities between the ages of 8-16, please disregard the age ranges. You may select from all 5 sessions. Placement will be based on best fit for your camper.

Campers:		**PC Campers (Ages 14-16, may select from all 5 sessions)**	
	Session 1 – June 25 – July 3, 2018 – *8-11 yrs old*		**Session 1 – June 25 – July 3, 2018**
	Session 2 – July 6 – July 15, 2018 – *11-14 yrs old*		**Session 2 – July 6 – July 15, 2018**
	Session 3 – July 18 – July 27, 2018 – *8-11 yrs old*		**Session 3 – July 18 – July 27, 2018**
	Session 4 – July 31 – August 9, 2018 – *11-14 yrs old*		**Session 4 – July 31 – August 9, 2018**
	Session 5 – August 12 – August 18, 2018 – *8-14 yrs old*		**Session 5 – August 12 – August 18, 2018**

Transportation:

Arrival	**Departure**
☐ I will drive my child to camp in Angola, NY	☐ I will pick up my child from camp in Angola, NY
☐ My child will take the bus from Stanley Makowski School in Buffalo, NY to camp will require: ☐ wheelchair accessible bus ☐ one-on-one aide	☐ My child will take the bus to Stanley Makowski School in Buffalo, NY from camp will require: ☐ wheelchair accessible bus ☐ one-on-one aide

Ethnicity: *(Optional)*

☐ African American ☐ Asian ☐ Bi-Racial ☐ Caucasian ☐ Hispanic ☐ Middle Eastern ☐ Native American

Household Information:

Total number of people living in your household including camper: _____

List any other 8-16 year olds that will be attending camp from the household besides applicant:_____

_____

Who has custody or legal guardianship of the camper? _____

Are there any custody issues? ☐ No ☐ Yes, If Yes please explain _____

_____

Education:

Classroom Type:

☐ General Education ☐ 6:1:1 ☐ 8:1:1 ☐ 12:1:1 ☐ 15:1 ☐ UG ☐ Inclusion ☐ Other: _____

Does your child have an IEP or ISP? ☐ Yes ☐ No If Yes, please provide a copy to camp.

Does your child receive counseling services: ☐ No ☐ Yes ☐ At School ☐ At Agency ☐ At Both School & Agency

Name of Counseling Agency: _____

Agency Services: **(***For Example: Aspire, Autistic Services, SKIP, People Inc., Summit, ECDSS, etc.)* ☐ Check box if does not apply

Agency 1 Name : _____ Case Number / TABS # :_____

Service Coordinator / Case Manager Name: _____

SC / CM Phone No.: (____)_____ SC / CM Email: _____

Agency 2 Name : _____ Case Number / TABS # :_____

Service Coordinator / Case Manager Name: _____

SC / CM Phone No.: (____)_____ SC / CM Email: _____

Check box if you receive any of the following county assistance programs:

☐ Family Assistance Benefits ☐ Food Stamps ☐ Child Welfare Services

Check box if your camper is: ☐ Foster Care ☐ Kinship Care ☐ Adopted

Camper Interests: *(PLEASE complete questions below to help the staff to get to know your child better.)*

What does your child like to do?

_____

_____

What strategies are used to manage your child's behavior?

_____

_____

What **rewards** work for good behavior?

_____

_____

What does your child dislike to do?

_____

_____

What things **upset** your child?

_____

_____

How does he / she express anger or frustration?

_____

_____

Behavioral Issues: *(Please check all that apply)*

☐ Does not sleep through night	☐ Inappropriate language	☐ Self injurious
☐ Wanders / runs away	☐ Inappropriate sexual behaviors	☐ Hits/ Kicks others
☐ Non-Compliant	☐ Destroys property	☐ Bites
☐ Eats inedibles	☐ Collects items that do not belong to them.	

Helpful Techniques to manage these behaviors:

_____

_____

Does your child have a Behavior Intervention Plan at his/her school or agency? ☐ Yes ☐ No.
If yes please provide us a copy.

Emergency Contact Information: *(PLEASE NOTE: We will attempt to contact Parents/Guardians FIRST, but we MUST have **2 contacts** that are not the parents/ guardians that are able to transport your child in case of emergency.)*

Emergency Contact 1	Emergency Contact 2
Name:	Name:
Relationship to Camper:	Relationship to Camper:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

Present Medication: *(As required by NY State law All Medications including Over the Counter Medications will be dispensed only by our nursing staff. All medications listed below must match physician / practitioners orders. Any script changes before arrival to camp must be forwarded to camp as soon as possible for review.)*

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

 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

General Allergies:

Check Box if Does Not Apply ☐

☐ **Dust** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Mold** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Insect** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Animal** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Seasonal** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Other** (please specify):_____

Reaction:_____ Treatment:_____

☐ **Allergies to Medications**

Medication:_____Reaction:_____Treatment:_____

Medication:_____Reaction:_____Treatment:_____

Medication:_____Reaction:_____Treatment:_____

Medication:_____Reaction:_____Treatment:_____

☐ **Latex Allergy**

Reaction:_____ Treatment:_____

☐ **Sunscreen or PABA Allergy**

Reaction:_____ Treatment:_____

☐ **Allergies to Food:** *(For Example: lactose, dye allergy, specific food)*

Reaction:_____ Treatment:_____

Reaction:_____ Treatment:_____

Reaction:_____ Treatment:_____

Special Dietary Needs:

Check Box if Does Not Apply ☐

(Please Note: Cradle Beach is a Peanut / Tree nut Free Facility)

☐ **Gluten** → *Please supply supplementary Gluten Casein Free products and snacks for your child for the camping session. Please label all items with your child's name.*

☐ **Casein** →

☐ **Diabetic** *(Provide to our nursing staff suggested carb counting and all special instructions provided by your physician / practitioner or dietary specialist)*

☐ **Lactose Intolerant** _____

☐ **Vegetarian**_____

☐ **Food Restrictions** _____

☐ **Low Calorie**_____

Is Portion Control needed? ☐ Yes ☐ No

Disability / Diagnosis: *(Check all that apply)* Please check box if section does not apply ☐

☐ Epilepsy / Seizures – Type of Seizure: _____ Date of Last Seizure:_____
☐ Absent Sweat Gland
☐ ADHD - Attention Deficit Hyperactive Disorder
☐ ADD – Attention Deficit Disorder
☐ APD – Auditory Processing Disorder
☐ Asthma - ☐ Allergic Rhinitis ☐ Exercise Induced ☐ Other:_____
☐ Autism – ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Other:_____
☐ Celiac Disease
☐ Cerebral Palsy
☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Pre-diabetic
☐ Down Syndrome
☐ Duchenne Muscular Dystrophy
☐ Fine Motor Skills Delay
☐ GERD - Gastroesophageal reflux disease
☐ Global Apraxia / Developmental Dyspraxia
☐ Global Developmental Delay
☐ Gross Motor Skills Delay
☐ Hearing Disabilities - ☐ Partial Hearing Loss ☐ Total Hearing Loss ☐ Cochlear Implant ☐ Uses Hearing Aids
☐ Heart Condition - ☐ Heart Defect ☐ Murmur ☐ Hypertension ☐ Other:_____
☐ Hypothyroidism
☐ Intellectual Disabilities
☐ Learning Disabilities
☐ Mental Health Issues - ☐ Adjustment Disorder ☐ Anxiety ☐ Bi-polar ☐ Depression
☐ Mood Disorder ☐ OCD - Obsessive Compulsive ☐ Phobia
☐ PTSD - Post Traumatic Stress Disorder ☐ RAD - Reactive Attachment Disorder
☐ Multiple Sclerosis
☐ Neurological - ☐ VP Shunt ☐ TBI ☐ Tourettes ☐ Tics ☐ Migraines ☐ Moya Moya ☐ Other:_____
☐ ODD - Oppositional Defiant Disorder
☐ PICA
☐ Prader-Will Syndrome
☐ Rett Syndrome
☐ Sensory Processing Disorder
☐ Scoliosis
☐ Sleep Apnea
☐ Spina Bifida
☐ Williams Syndrome
☐ Speech / Language Delay
☐ Speech / Language Impairment
☐ Vision Disabilities - ☐ Glasses ☐ Contact Lenses ☐ Legally Blind ☐ Nystgmus ☐ Visually Impaired
☐ Other: _____

Permission Page: *(Please Note: This page must be completed and signed for your application to be processed.)*

Pool Usage information:

Is your child allowed to participate in life guard supervised time in our pool? ☐ Yes ☐ No

If No, Can you explain:_____

Please describe any concerns, restrictions or adaptations regarding your child's time in our pool:_____

_____

Does the child have ear tubes? ☐ Yes ☐ No

Program Information:

Can Cradle Beach use your child's name, photograph, and / or video for publicity purpose? ☐ Yes ☐ No

Cradle Beach does programming during camp to celebrate different holidays, festivals, celebrations and events. Would your child be allowed to participate? ☐ Yes ☐ No, If no please explain: _____

_____

Parent/Guardian Commitment:

(Please check all the boxes on the left to show that you have read and agreed to each statement.)

☐ 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 give Cradle Beach permission to contact my child's school or agency personnel to release information (i.e. Counseling Services, Individual Education Plan, Behavioral Intervention Plans, and Individual Service Plan.)

☐ I will not hold Cradle Beach accountable for any items my child might bring to camp. (For Example: clothing, money, valuables or electronic items.)

☐ I agree not to visit my child at camp. Please notify us if a message needs to be relayed to your child.

☐ I agree to communicate with my child ONLY through letters or care packages. Staff will respond to calls within a reasonable amount of time. PLEASE understand our first priority is the children we are caring for and will make every effort to communicate with you as soon as possible.

☐ Cradle Beach reserves the right to send a child home. This could be for behavioral or medical reasons.

☐ I give permission for my child to have a photo taken with their cabin group as a memory of their time at camp. These photos WILL NOT be used for publicity. ONLY campers in the cabin will get these photos. We will make special accommodations for any camper who are in Foster Care or have restrictions.

I am aware:

☐ The $30 Application fee is non-refundable

☐ Camp fees will NOT be returned if your child is sent home for behavioral problems.

☐ Cancellation refunds of camp fees, must be requested in writing from the parent/guardian two weeks prior to the camper's arrival date.

☐ There will be a $25 charge for returned checks.

The Application was completed by: (print name): _____

Signature:_____ Date: _____

Relationship to Applicant:_____

Thank you for your interest in sending your camper to Cradle Beach this summer!!

***ONLINE REGISTRATION IS AVAILABLE!** You're eligible for a $15 discount on completed online applications. Go to: https://cradlebeach.campmanagement.com/enroll

Please Note:

1. Camper acceptance and placements are on a first come, first serve basis.
2. Only **completed** application packets will be processed.
3. Campers must be between **ages 8 – 16** on the FIRST DAY of the requested session in order to attend camp.

A completed application includes:

- ☐ **Application booklet – all pages completed**
- ☐ **$30 application fee** – *Check, Money Order, or Credit Card (please, no cash payments)*
- ☐ **Proof of Income** – *copies of household income include: recent paystub(s), W-2 form, Federal tax return, SSI or Disability, county-issued payments, adoption subsidy, or unemployment benefits*
- ☐ **Copy of Health Insurance/Medicaid Card**
- ☐ **Summer Food Services Form (Pink)**
  - **MUST** be completed by all families regardless of eligibility.
- ☐ **Erie County Dept. of Social Services (ECDSS) form(s)**
  - If you receive services through ECDSS (have an "S" or "P" at the beginning of your case number), complete the ECDSS form.
- ☐ **Authorization to Release Medical Information (Page 1 of Medical Packet)**
- ☐ **Camp Medical Release and Health Information (Page 3 of Medical Packet)**

****PLEASE NOTE:** If your camper is in ECDSS foster care, ALL signature pages of the application packet and ECDSS form(s) must be signed by guardian **AND** ECDSS caseworker**

Submit Separately (can be submitted via fax, mail, or email)

- ☐ **Teacher/Counselor Reference Form (Green)**
- ☐ **Physical and Over-the-Counter Medication Forms (Pages 4 – 6 of Medical Packet/Yellow)** – *physical must be completed within 12 months of campers last day of selected camp session.*

What is a Pioneer Camper (PC)?

Our Pioneer Camper (PC) Program is made up of selected young adults (ages 14 – 16) with leadership qualities. PC's participate in programs separately from the summer camp population. They also "work" doing various camp related service projects and fulfilling camp needs, such as serving meals to campers, being "buddies" with younger campers, and camp program participation and planning. Through these activities, PC's accumulate community service hours for which they receive a letter confirming the activities in which they participated and the total number of hours. They also participate in an end of session awards ceremony with their fellow PC's.

Fees:

Camp fees are on a sliding scale based on household income and number in the household. Please note that there is a multi-child discount available. There are also scholarships and payment plans available. Please see below for general fee information. This does not include multi-child discount.

CAMPER FEE SCALE

INCOME		NUMBER IN 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	170	140	110	100
$30,000	$34,999	240	210	180	150	120
$35,000	$39,999	280	250	220	190	160
$40,000	$44,999	320	290	260	230	200
$45,000	$49,999	360	330	300	270	240
$50,000	$54,999	400	370	340	310	280
$55,000	$59,999	440	410	380	350	320
$60,000	$64,999	480	450	420	390	360
$65,000	$69,999	520	490	460	430	400
$70,000	$74,999	560	530	500	470	440
$75,000	$79,999	600	570	540	510	480
$80,000	$84,999	640	610	580	550	520
$85,000	$89,999	680	650	620	590	560
$90,000	$94,999	720	690	660	630	600
$95,000	$99,999	760	730	700	670	640
$100,000	$124,999	800	770	740	710	680
$125,000	up	840	810	780	750	720

PC FEE SCALE

INCOME		FEE
$0	$24,999	100
$25,000	$49,999	150
$50,000	$74,999	200
$75,000	$99,999	250
$100,000	$124,999	300
$125,000	Up	350

If you have any questions or need assistance or clarification, please feel free to contact us at
Phone: (716) 549-6307 ext 205.
Email: admissions@cradlebeach.org

Camper Medical Information Packet

Dear Parent/Guardian:

Attached is a set of pages that will answer all the questions camp needs in regards to your camper's medical history.

Page 1 (bottom) – Authorization to release medical information, allows camp to contact the camper's physician to assist in collecting the camper's physical. ***This is to be filled out by the parent / guardian and returned with the application.***

Page 2 – Is an information sheet from the NY State health department in regards to meningococcal meningitis.

Page 3 – Is the Parent / Guardian Medical Disclaimer and Meningococcal Meningitis Vaccination Response Form. ***This is to be filled out by the parent / guardian and returned with the application.***

Page 4 – 6 – Camper's Physical Form – these pages must be filled out by camper's physician or practitioner. Camper's physical exam must be within 12 months of the end date of their camping session.

- Please review your child's physical form to assure all the medications your child requires are listed on the form prior to submitting it to Cradle Beach camp. This includes the need for immunization records. If your child requires medications prescribed by another practitioner, i.e. a psychiatrist or specialist, we will require written orders from them as well.

- If your child's physical expires before he/she attends camp please call your doctor's office to schedule an appointment right away. Doctor's office visit slots fill up very quickly in the summer.

Authorize to release medical information:

As the parent/guardian of_____, I authorize my child's
(camper's name)

medical information, prescriptions to be released to Cradle Beach during the time my child attends camp. I give my _____
(Physician's Office)

at (_____)_____ , (_____) _____
phone # fax #

or pharmacy permission to fax my child's physical and/or prescriptions to Cradle Beach at (716) 549-6825. I authorize any physician, nurse or health care provider, to communicate with the medical staff and director of Cradle Beach about my child's medical condition treatment and/or prognosis. I further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or my child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child.

Parent / Guardian Signature: _____

Date: _____

We am writing you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-1 of the State Sanitary Code requires overnight children's camp to distribute information about meningococcal disease and vaccination to all campers who attend camp for seven (7) or more days.

Cradle Beach is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parents or guardian: AND EITHER
- A record of meningococcal meningitis immunization **OR**
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and spinal cord. It is also causes blood infections.

About 1,000-1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease but it most common in infants under one year of age and those 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshman living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who contract the disease dies from it and many others are affected for life. This is why prevention through use of a vaccination is important for those at highest risk.

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for those 55 years of age and younger. For example, 2 MCV4 vaccines are Menactra™ and Menveo™. The Centers for Disease Control and Prevention (CDC) recommend two doses of MCV4 for adolescents 11 through 18. The first does at 11 or 12, with a booster does at age 16. If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.
- Meningococcal polysaccharide vaccine (MPSV4) has been available since the 1970s. It is the only meningococcal vaccine licensed for those over 55 years old. The name of MPSV4 is Menomune™.

Both vaccines can prevent four (4) types of meningococcal disease, including two of the three most common types in the United States and one that causes epidemics in Africa. There are other types of meningococcal disease: the vaccines do not protect against these.

Information about the availability and cost of the vaccine can be obtained from your health care provider. Cradle Beach does not offer meningococcal immunization services.

We encourage you to carefully review this information. Please complete the Meningococcal Vaccination Response Form Section (on next page). If this form is not completed, your child will not be accepted to camp. Your child can attend camp if they have not received the vaccine.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information on the CDC website: https://www.cdc.gov/vaccines/vpd/mening/public/index.html.

Camper's Name:_____ DOB: _____

MEMINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to camp.

Please check the appropriate box and complete the bottom

☐ **My child has received the meningococcal conjugate vaccine (MCV4), for example Menactra or Menveo. Date received:**

(Note: The Centers for Disease Control and Prevention recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first does at 11 or 12 years of age with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at age 11 or 12 years old, plus a booster at age 16. If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.)

☐ I have read or have had explained to me, the information regarding meningococcal meningitis disease. **My child is currently under the age of 11.**

☐ 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:_____Date:_____

Parent Guardian Medical Disclaimer / Agreement

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 change. I wish to be notified.

If emergency treatment is necessary, I give permission for my child to be brought to Lakeshore Hospital or the nearest emergency room available by ambulance or camp vehicle 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: *(please check one)*

☐ **Children's Hospital** ☐ **ECMC** ☐ **Mercy** ☐ **Buffalo General** ☐ **Brooks Hospital**

I will provide all necessary medications and supplies needed by 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 the medication/supply after my notification. We will bill you directly if there is no medical insurance.

In consideration of admissions 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:_____

Camper Medical Information:

Name of Physician / Practitioner:_____

Telephone #:_____ Fax #:_____

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):_____

_____

Physical Form

Mail or fax complete forms:
Cradle Beach
8038 Old Lakeshore Rd.
Angola, NY 14006

Phone: 716-549-6307
FAX: 716-549-6825

Camper's Name:_____ DOB: _____ Date of Exam:_____

Physician's/Practitioner's Name:_____

Physician's/Practitioner's Phone:_____Physician's/Practitioner's Fax:_____

Please complete, sign and date all three pages and attach a copy of the most current immunizations records.
Camper's physical exam must be within 12 months of the end date of their selected camping session.

DIAGNOSIS	STATUS

Children with Down Syndrome C-Spine films are recommended

Results:

Allergies	Reaction	Treatment

HT:	WT:	HR:	BP:	RR:

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEENT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMETIES			
NEURO			
SKIN			

Camper's Name:_____DOB:_____ Date of Exam:_____

MEDICATION:

- All current medications must be listed, including any over the counter medications. Please include all reasons for giving medication

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

Can this child go into a life guard supervised pool? ☐ Yes ☐ Yes – with 1-on-1 supervision ☐ No

If No, please explain:_____

Is the camper diagnosed with Seizures? ☐ Yes ☐ No Type:_____ Date of Last Seizure:_____

Does the Camper have any restrictions? ☐ Yes ☐ No

If Yes, please describe:_____

Other orders or recommendations: *(including instructions for care of skin, bowel or catheterization)*

_____

_____

NYS Health Department requires all the following information:

Physician/Practitioner Signature:_____ Exam Date:_____

Printed Name:_____ License Number:_____

Address:_____ Phone: (_____)_____

City:_____State:_____Zip:_____ Fax: (_____)_____

New York State Public Health 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 Department of Health
2. Cradle Beach is required to be inspected twice yearly.
3. Inspection reports concerning camp are on file at the Erie County Department of Health, Rath Building, Buffalo, NY

Camper's Name:_____DOB:_____ Date of Exam:_____

Over the Counter Medication Form (OTC)

Your physician/practitioner must complete this form. If we do not receive this form your child will not be able to receive any OTC medication while at camp.

Each item must have either a yes or no checked. Please do not leave blank.

☐ 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 that has a "yes" box checked may be given to the above named child at Cradle Beach Camp after nursing assessment.

Physician/Practitioner Signature:_____

Print Name:_____Date:_____

MUST BE FILLED OUT EVEN IF YOU DO NOT QUALIFY

(PINK)

Cradle Beach

where children's spirits soar

• SINCE 1888 •

Summer Food Parent Letter

Cradle Beach is participating in the Summer Food Service Program. Meals will be provided to all children who attend camp. However, Cradle Beach receives funding for all children who are eligible for free or reduced meals (to be eligible to receive free meals, children must meet the income guidelines for reduced price meals in the National School Lunch Program). Children who are part of households that receive food stamps or benefits under the Food Distribution Program on Indian Reservation (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible to receive free meals. The following 2017- 2018 income eligibility standards will be used for determining eligibility for free meals:

Income Eligibility Guidelines

Household Size	Year	Month	Twice per Month	Every Two Weeks	Weekly
1	$22,311	$1,860	$930	$859	$430
2	$30,044	$2,504	$1,252	$1,156	$578
3	$37,777	$3,149	$1,575	$1,453	$727
4	$45,510	$3,793	$1,897	$1,751	$876
5	$53,243	$4,437	$2,219	$2,048	$1,024
6	$60,976	$5,082	$2,541	$2,346	$1,173
7	$68,709	$5,726	$2,863	$2,643	$1,322
8	$76,442	$6,371	$3,186	$2,941	$1,471
For each additional family member, add	$7,733	$645	$323	$298	$149

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print. audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in language other than English.

Camp and/or closed enrolled site information

Session Name & Date	Meals Available	Service Times
Session 1: 06/25/2018- 07/03/2018	Breakfast, Lunch, Dinner	8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM
Session 2: 07/06/2018- 07/15/2018	Breakfast, Lunch, Dinner	8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM
Session 3: 07/18/2018- 07/27/2018	Breakfast, Lunch, Dinner	8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM
Session 4: 07/31/2018- 08/09/2018	Breakfast, Lunch, Dinner	8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM
Session 5: 08/12/2018- 08/18/2018	Breakfast, Lunch, Dinner	8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM

Please fill out and return an "Application for Free and Reduced Price School Meals/Milk" to Cradle Beach 8038 Old Lakeshore Rd. Angola, NY 14006. This application must be filled out even if you do not qualify. If you have any questions please feel free to contact Cradle Beach Camp at (716) 549-6307 x 205.

To file a program complaint of discrimination, complete the USDA Program Discrimination Form, (AD-3021) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Nancy L Sirmo — 1/2/2018

(Signature of Authorized Representative) (Date)

8038 Old Lakeshore Rd, Angola, NY 14006 (716) 549-6307 (716) 549-6825 (FAX)

INCOME ELIGIBILITY FORM FOR THE
SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to: Cradle Beach.
If you need help, call (716) 549-6307 x 205.

Follow these instructions, if your household gets SNAP (Food Stamps) TANF or FDPIR:
Part 1: List participant's name and a SNAP (Food Stamp), TANF or FDPIR case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is NOT required.
Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:
Part 1: Enter the child's name.
Part 2: Please contact us at [phone number of Sponsor]
Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.
Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:
Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.
Column A–Name: List the first and last name of each person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.
In Box 1, list the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
In box 2, list the amount each person got last month from welfare, child support, alimony.
In box 3, list Social Security, pensions, and retirement.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Column C–Check if no income: If the person does not have any income, check the box.
Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.
This institution is an equal opportunity provider.

Must be filled out even if you do not qualify.

Part 1. Children enrolled in Camp or Closed Enrolled Sites.	
Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **Cradle Beach at (716) 549-6307 x 205.** Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** Example: $100/monthly $100/twice a month $100/every other week $100/weekly				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
2.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
3.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
4.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
5.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
6.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
7.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
8.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
9.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
10.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
11.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐
12.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	☐

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X_____Print name:_____Date:_____

Address:_____ Phone Number: _____

Last four digits of Social Security Number: __ __ __ __ ☐ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income:_____Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year

Household size:

Categorical Eligibility:___Date Withdrawn:_____ Eligibility: Free___Reduced___Denied___

Reason:_____

Determining Official's Signature:_____ Date:_____

Confirming Official's Signature:_____ Date:_____

Follow-up Official's Signature:_____ Date:_____

Return this page with Camper/PC Application Booklet: We cannot accept a faxed copy.

Erie County Department of Social Services
Assistance Packet

Instructions for Families that receive services through ECDSS

If you receive public assistance or service assistance through Erie County Department of Social Services (ECDSS) and you have a case number that starts with an "S" or "P", you might be eligible to receive funding through the county to help cover the cost of your camper's fees. Please complete the **Authorization for Release of Information by ECDSS**, attached. We will contact Erie County Department of Social Services (ECDSS) to verify if you qualify for help to cover the cost of your child's camper fee.

Instructions for Foster Parent/Guardian with Foster Children in Erie County

The following pages are to be signed by the ECDSS Caseworker as well as Foster Parent/Guardian:

- **Authorization for Release of Information by ECDSS** (attached)
- **Summer Camp Permission Form for Foster Care Children** (attached)
- **The Summer Food Service Packet** (Pink)
- **The Medical Release of Information Form** (Yellow) – Page 1
- **The Medical Disclaimer and Meningococcal Meningitis Vaccination Response Form** (Yellow) - Page 3
- **The Permission Page** (The Camper/PC Application Packet) – Page 7

AUTHORIZATION FOR RELEASE OF INFORMATION
BY THE ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

Camper's Name: _____ **Date of Birth: _____**

Address: _____ _____ _____ _____
Street City State Zip

I hereby authorize the use or disclosure of my (**Public Assistance** / **Service Assistance**) information as described below. I understand that this authorization is voluntary, but is required to participate in the Erie County Department of Social Services Summer Camp Program.

Persons/organizations providing the information:

Erie County Department of Social Services
95 Franklin Street
Buffalo, New York 14202

Persons/organizations receiving the information:

Summer Camps- for the purpose of determination of eligibility for ECDSS Summer Camp Program (to pay camper's fees up to allowable amount).

CAMP NAME: CRADLE BEACH

1. Information to be released:

Verification as to whether the child applying for camp is active in a Temporary Assistance (cash welfare) case, or has a Foster Care case opened with ECDSS.

2. Purpose of the use/disclosure:

Determining eligibility for participation in ECDSS Summer Camp Program (ECDSS to pay for camp).

This authorization will expire one year after being signed.

_____ _____
Signature of parent or guardian Date

Print name of individual's personal representative _____

Relationship to camper: _____

B-5705 (3/15)

County of Erie

DEPARTMENT OF SOCIAL SERVICES

SUMMER CAMP PERMISSION FORM FOR FOSTER CARE CHILDREN

Camper's Name: _____ **Date:** _____

Case Number: _____

Caseworker's Name: _____

This form serves to give permission for the above-named foster child, who is in the care and custody of the Erie County Department of Social Services, to attend summer camp as follows:

CAMP NAME: CRADLE BEACH

SESSION DATES: ___/___/___ through ___/___/___

The above-named camper has permission to participate in all camp activities that he/she is medically approved to participate in, with the following exceptions:

- ☐ No exceptions; camper may participate in all camp activities
- ☐ Camper's photo may not appear in any promotional materials for the camp
- ☐ Special Instructions:

_____
_____
_____

In the event of an incident or emergency of any kind that would necessitate the calling of parents, the camp MUST notify the Erie County Department of Social Services immediately. The undersigned gives permission for the above-named child to receive emergency medical attention if necessary.

Signed: _____ (Guardian/Custodian)

_____ (Caseworker)

Caseworker Telephone Number: _____

B-5706 (5/16)