Caregiver's Respite Weekend Application

March 9th - March 11th at Cradle Beach Camp

Mail Application to:
Cradle Beach
8038 Old Lakeshore Rd
Angola, NY 14006
or
Fax : (716) 549-6825

PLEASE NOTE TO BE ELIGIBLE TO PARTICIPATE:

- **Age between 8 - 16 years old**
- **Be able to provide written proof that the participant is in Foster Care, Kinship Care or a Post-Adoption child.**

Camper Information: Please print all information clearly

Last Name: ______________________________ First Name: ________________________ Middle Initial: _____

Address: __________________________________ City: __________________ State: ________ Zip: ________

County: ___________________________________ Telephone Number: (_____)__________________________

☐ Male ☐ Female Grade : _____________ Date of Birth: ____________ Age: _______

School Name: ____________________________ School District: ___________________________

Parent/Guardian 1:

Name: ____________________________________

Relationship to Camper: ______________________

Cell Phone:(_____) ___________________________

E-mail Address:_______________________________

Employer: ___________________________________

Work Phone: (_____) __________________________

Parent/Guardian 2:

Name: ____________________________________

Relationship to Camper: ______________________

Cell Phone:(_____) ___________________________

E-mail Address:_______________________________

Employer: ___________________________________

Work Phone: (_____) __________________________

Emergency Contact Information: (Persons must be able to transport your child)

→ **Parents/Guardians will be contacted FIRST.**
→ **Other than parents, emergency contacts will only be allowed to pick up your child**

Emergency Contact # 1 Name (Not parent/guardian): ____

Relationship to Child: _________________________________ Home # (_____)____________________

Cell # (_____)______________________ Work # (_____)____________________

Emergency Contact # 2 Name (Not parent/guardian): ____

Relationship to Child: _________________________________ Home # (_____)____________________

Cell # (_____)______________________ Work # (_____)____________________

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

Agency Services:

Agency 1 Name: ______________________________ Case Number/ TABS #: ____________________

Service Coordinator/Case Manager: ______________________ Telephone: (_____)____________________

Case Name (Guardian/Parent) ____

Agency 2 Name: ______________________________ Case Number/ TABS #: ____________________

Service Coordinator/Case Manager: ______________________ Telephone: (_____)____________________

Case Name (Guardian/Parent) ____

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

Family Assistance Benefits: ☐ Yes ☐ No   Receive Food Stamps: ☐ Yes ☐ No

Child Welfare Services: ☐ Yes ☐ No   Foster Care: ☐ Yes ☐ No

Camper Interests / Needs:

→ Complete questions below to help the counselors to get to know your child better.

→This information will help your child while he/she is at camp.

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 **not like 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
☐ Wanders/runs away
☐ Non-compliant
☐ Eats inedibles
☐ Inappropriate language
☐ Inappropriate sexual behaviors
☐ Destroys property
☐ Collects items that do not belong to them
☐ Self injurious behaviors Hits/
☐ Kicks others
☐ Bites
☐ Other : ________________

Helpful techniques to manage these behaviors: ____________________________________

____

____

Disability/ Diagnosis Information: ☐ Does Not Apply

☐ **Attention Deficit Hyperactive Disorder (ADHD)**
☐ **Attention Deficit Disorder (ADD)**
☐ **Auditory Processing Disorder (APD)**
☐ **Asthma**
☐ **Intellectual Disabilities** ______________________________
☐ **Learning Disabilities** ________________________________
☐ **Mental Health Issues (Must be diagnosed)**
  ☐ Adjustment Disorder ☐ Anxiety ☐ Bi-polar ☐ Depression ☐ Mood Disorder
  ☐ Obsessive Compulsive (OCD) ☐ Phobia ☐ Post Traumatic Stress Disorder (PTSD)
☐ **Reactive Attachment Disorder (RAD)**
☐ **Oppositional Defiant Disorder (ODD)**
☐ **Sensory Processing Disorder**
☐ **Other** ____

Physician / Medical Information:

Name of Physician/ Practitioner: ____

Telephone #: (______)____________________ Fax #: (______)_________________

Most recent or pending date of physical: __________________________

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, 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 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:**
☐ Children's Hospital (WCHOB) ☐ ECMC ☐ Mercy ☐ Buffalo General ☐ Brooks Hospital

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

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:** ____________________

Food/Dietary Needs: **Please note: Cradle Beach is Peanut/ Treenut Free**

Special Dietary Needs: ☐ **Does Not Apply**

Please give details for any dietary needs/restrictions

☐ **Gluten** →

☐ **Casein** →

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. We will contact you about your child's dietary needs.

☐ **Diabetic** (Parents **must** provide suggested carb counting/ substitutions provided by your physician/ practitioner or dietary specialist)

☐ **Lactose Intolerant** ____

☐ **Vegetarian** ____

☐ **Food Restrictions** ____

☐ **Low Calorie** ____

Is Portion Control needed? ☐ Yes ☐ No

Health Insurance Information:

! YOU MUST SEND A COPY OF A CURRENT INSURANCE CARD

(If we do not receive a copy, your child cannot be accepted)

Physical Information:

→ Camp must receive Cradle Beach physical or physician's/practitioner's electronic physical form.
→ We will not accept school physical forms
→ Camp must receive Over the Counter (OTC) Form.
→ Camper's physical exam must be within 12 months of the end date of their camping session.
→ NYS Health Department requires that we have a copy of your child's immunization record.

Present Medications: **Must match physician/practitioner orders for medication**

→ NYS law requires **all medication including Over the Counter Medication** to be dispensed only by physician's / practitioner's orders.
→ Please include all medications, inhalers with frequency and/or nebulizer treatments.
→ Any changes prior to camp arrival must be accompanied with current prescription.

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

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, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audio tape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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.
USDA is an equal opportunity provider, employer, and lender.

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

Allergy Information: ☐ Does Not Apply

General Allergies:

☐ **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 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: ____________________

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

Food: ______________ Reaction: ______________ Treatment: ______________

Food: ______________ Reaction: ______________ Treatment: ______________

Food: ______________ Reaction: ______________ Treatment: ______________

Parent and Camper Consent Page

*** * This form must be read and signed by both parent/guardian and potential camper.****

- **By signing this Code of Conduct, you are stating that you will follow the rules of Cradle Beach during your entire time at camp.**
- **Your child must check the box ☑ after reading and agreeing to each statement.**

1) I will be helpful and follow directions given by adult leaders while I'm at camp. ☐
2) I will not bully nor harass other campers, staff and counselors. ☐
3) I will not use any form of physical or verbal violence towards other campers and staff. ☐
4) I will use appropriate humor and language. ☐
5) I will participate in all programs with a positive attitude. ☐
6) I will keep all expensive items such as cell phone, smart phone, iPods, other electronics, money and jewelry at home. ☐
7) I will wear appropriate clothing. I will not wear gang symbols or logos that are offensive. ☐
8) I will not bring inappropriate literature, alcohol, tobacco, drugs or weapons to camp. ☐
9) I will keep all medications in the infirmary. ☐
10) I understand that I may be sent home from camp if I do not follow the rules stated above. ☐

Camper's Signature: ___________________________________

Parent / Guardian Permission Section

****Please check all boxes to indicate you have read, understood and agreed each statement****

☐ I give my chld permission to attend Cradle Beach Camp and participate in all recreational and educational activities.

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

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

☐ I give permission for my camper to have a professional photo taken of them with their cabin group. Only the campers in the cabin will receive a copy of the photo. This photo will not be used for camp publicity.

Parent/Guardian Signature:____Date:__________

Any questions can be addressed to Program Coordinator at 549-6307 ext. 205 or admissions@cradlebeach.org.

PLEASE SUBMIT THIS PAGE WITH YOUR APPLICATION!

Dear Parent/Guardian:

Please have your child's physician or practitioner complete the next 3 pages of this physical.

Campers' 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.

Remember any medication changes made after physical is completed, requires you to send in or bring with you a copy of the new script from your physician.

Physical must be submitted 30 days prior to camp start date to ensure campers spot. If there is an issue to meet this requirement, you must contact the admissions office immediately.

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.

Please complete the following before turning physical to your physician or practitioner.

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 ____at (______)________________ ,(________)_____________
(Doctor's Office) (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: _____________________________

PHYSICAL FORM (Page 1)

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

CAMPER'S NAME: ______________________________ **DOB:** ________________ **Date of Exam:** ____________

Physician's/Practitioner's Name __________________________________

Physician's/ Practitioner's Phone (___) ________________ **Physician's/ Practitioner's Fax (___)**____________

Please Note: Physician/Practitioner must complete all 3 pages enclosed. Sign and Date. Please include a copy of recent immunization records.
Campers physical exam must be within 12 months of the end date of their camping session

DIAGNOSIS	STATUS

Children with Down Syndrome C-Spine films are recommended

Results: ____

ALLERGIES DOES NOT APPLY	REACTION	TREATMENT

HT__________ **WT**___________ **HR**___________ **BP**__________ **RR**______________

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

(YELLOW)

CAMPER'S NAME ________________________ DOB ______________

PHYSICAL (Page 2) DATE OF EXAM______________

MEDICATION

- All current medications must be listed, including any over the counter medications.
- **Reasons must be given for each medication.**
- **Any medication changes after exam date must be accompanied by a current written prescription from camper's physician/practitioner.**

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

Seizures ☐ **Yes** ☐ **No** **Type:** ______________ **Last Episode:** ________

Restrictions ☐ **Yes** ☐ **No** **Describe:** ________________________

____

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

____

____

NYS Health Department requires all of the following information:

Physician/Practitioner Signature ____________________ **Exam Date** ______________

Printed Name ______________________ **License Number** ______________

Address ______________________ **Phone (   )**______________

City ______________ **State** ______ **Zip** ______ **Fax (   )**______________

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3. Inspection reports concerning camp are on file at the Erie County Dept. of Health, Rath Building, Buffalo, NY

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8038 Old Lakeshore Rd
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CAMPER'S NAME: ______________________________ **DOB:** ________________

OVER THE COUNTER MEDICATION FORM (OTC) (Page 3)

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

Each medication must be checked √ either "yes" or "no"

☐ Yes ☐ No **Bactine** (topical) for minor wound care, first aid as needed

☐ Yes ☐ No **Triple Antibiotic Ointment** (topical) for wound healing

☐ Yes ☐ No **Tylenol** (oral) as directed on bottle for age/weight

☐ Yes ☐ No **Ibuprofen** (oral) as directed on bottle for age/weight

☐ Yes ☐ No **Chloraseptic Spray** for sore throat as needed

☐ Yes ☐ No **Cough Drops** for coughing, minor throat irritation as needed

☐ Yes ☐ No **Antacid Tablet** (oral) for stomach discomfort

☐ Yes ☐ No **Miralax** (oral) laxative as directed on bottle for age/weight

☐ Yes ☐ No **Benadryl** (oral) for swelling, hives, allergic reaction as directed on bottle for age/weight

☐ Yes ☐ No **Loratidine** (oral) for seasonal allergy symptoms, as directed on bottle for age/weight

☐ Yes ☐ No **Calamine Lotion or Cortaid** (topical) for insect bites/ bee stings

☐ Yes ☐ No **Visine/ Murine Plus Eye Drops** (topical in eye) for minor eye irritation

☐ Yes ☐ No **Sunscreen**

☐ Yes ☐ No **Insect/Bug Repellent**

☐ Yes ☐ No **Other** (please describe) ________________________________

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

Physician/Practitioner Signature: ________________________________ **Date:** ____________

Print Name: ________________________________

(YELLOW)