Cradle Beach
where children's spirits soar
SINCE 1888

Caregiver's Respite Weekend Application

May 3rd - May 5th, 2019
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:

- **Ages 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
Kinship Care:	☐ Yes	☐ No	Post Adoptive:	☐ Yes	☐ No

Household Information:

Total number of people living in your household including camper: ____ Are there any custody issues? ☐ No ☐ Yes

Who has custody or legal guardianship of the camper? _____

PLEASE list all members living in the household and their relationship to camper

Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____
Name: _____ Age: ____ Relationship: _____

Camper Interests / Needs:

→ Complete questions below to help the counselors 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**? _____
_____

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:**
☐Oishei Children's Hospital ☐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

Disability/ Diagnosis Information: ☐ Does Not Apply

☐ **Attention Deficit Hyperactive Disorder (ADHD)**
☐ **Asthma**
☐ **Intellectual Disabilities** _____
☐ **Learning Disabilities** _____
☐ **Mental Health Issues (Must be diagnosed)**

☐ Adjustment Disorder ☐ Anxiety ☐ Bi-polar Disorder ☐ Depression
☐ Mood Disorder ☐ OCD - Obsessive Compulsive Disorder
☐ ODD - Oppositional Defiant Disorder ☐ Phobia
☐ PTSD - Post Tramumatic Stress Disorder ☐ RAD - Reactive Attachment Disorder

☐ **Other**_____

Behavioral Issues: Please check all that apply

☐ Wanders/runs away
☐ Destroys property
☐ Non-compliant
☐ Physically aggressive
☐ Inappropriate language
☐ Hits / Kicks others
☐ Eats inedibles
☐ Self injurious
☐ Inappropriate sexual behaviors to self
☐ Inappropriate sexual behaviors to others
☐ Collect items that do not belong to them
☐ Does not sleep through the night

Helpful techniques to manage these behaviors: _____

_____

_____

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

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

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

Phone: 716-549-6307 ext. 205
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			
EXTREMITIES			
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: (_____)_____

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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 have 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:_____