



## Physical Form

Mail or fax complete forms:  
 Cradle Beach  
 Attn: Admissions  
 8038 Old Lakeshore Road  
 Angola, NY 14006  
 Phone: 716-549-6307 ext. 205  
 Fax: 716-549-6825

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Physician's/Practitioner's Name: \_\_\_\_\_

Physician's/Practitioner's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please have your physician/practitioner complete, sign and date all three pages and attach a copy of the most current immunization records. Participant's physical exam must be within 12 months of the end date of their selected program.

DIAGNOSIS	STATUS

Participants with Down Syndrome C-Spine films are recommended. Results: \_\_\_\_\_

ALLERGIES	REACTION	TREATMENT

HT:	WT:	HR:	BP:	RR:
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SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEENT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITILIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			

Participant'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 medications.

Medication	Dosage	Times Given	Route	Reason	Please list any special ways to give the medication.

Can this participant go into a lifeguard supervised pool?  Yes  Yes – with 1-on-1 supervision/assistance  No

If No, please explain: \_\_\_\_\_

Is the participant diagnosed with Seizures?  Yes  No Type: \_\_\_\_\_ Date of Last Seizure: \_\_\_\_\_

Does the participant have any restrictions?  Yes  No

If Yes, please describe: \_\_\_\_\_

Other orders or recommendations: (Including instructions for skin, bowl or catherization)

**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 participant's 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.

Participant'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 participant will not be able to receive any OTC medication while attending programming at Cradle Beach.

**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/Acetaminophen (oral) as directed on bottle for age/weight.
- Yes  No - Motrin/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 - TUMS/Antacid Tablet (oral) for stomach discomfort.
- Yes  No - Miralax/Polyethylene glycol 3350 laxative (oral) as directed on bottle for age/weight.
- Yes  No - Benadryl/Diphenhydramine (oral) for allergic reaction as directed on bottle for age/weight.
- Yes  No - Claritin/Loratidine (oral) for seasonal allergy symptoms, as directed on bottle for age/weight.
- Yes  No - Zyrtec/Cetirizine (oral) for seasonal allergy symptoms, as directed on bottle for age/weight.
- Yes  No - Allegra/Fexofenadine (oral) for seasonal allergy symptoms, as directed on bottle for age/weight.
- Yes  No - Xyzal/Levocetirizine (oral) for seasonal allergy symptoms, as directed on bottle for age/weight.
- Yes  No - Calamine Lotion (topical) for insect bites/bee stings.
- Yes  No - Cortaid/Hydrocortisone (topical) for insect bites/bee stings.
- Yes  No - Visine/Tetryzoline Eye Drops (topical in eye) for minor eye irritation.
- Yes  No - Swim Ear/Drops (topical in ear) for swimmer ears for minor ear discomfort.
- 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 participant at Cradle Beach after nursing assessment.

Physician/Practitioner Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_