Dear Respite Parents and Agency Representatives,

The main goal of our Respite Program is to provide relief for family caregivers who are in need of a break from their daily responsibilities. We will use the facilities of camp and the skills of our trained camp staff to provide this service. Participants may attend one Respite weekend per year. Cradle Beach is a Home & Community Based Medicaid Waiver Program under OPWDD guidelines; there is no out of pocket expense for parents/guardians.

Criteria for inclusion in the Respite Program:
- Participant must be 8 years old or older and have a documented developmental disability.
- Participant must live at home with the family, and not in a group home or other institution.
- Participant must live in one of the seven counties of Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans)
- Participants must have a physical examination and physician signed Over the Counter Medication Form (OTC Form) within a year of their Respite weekend.

OPWDD guidelines require specific documentation to be allowed to participate in the Respite Program:

If applicant is new to the Cradle Beach Respite Program they MUST have:
- A documented negative TB test occurring within a year of their Respite weekend
- Request for Service Amendment (RSA)
- Front Door Policy
- Individual Service Plan (ISP)
- ISP addendum requesting Cradle Beach as a Respite Provider

** Check with your Medicaid Service Coordinator about required paperwork. **

Space is limited. Applications will be evaluated for placement on a first come first serve basis. If you need to cancel for a weekend that you are confirmed to participate in, PLEASE contact as soon as possible. We will attempt to reschedule based on availability. If you have any questions, please feel free to call us at any time. Once again, we look forward to providing you with our Respite services.

Gabriele Clark
Director of Campus Based Services
gclark@cradlebeach.org / (716) 549-6307 ext.206

Nancy S. Grimes
Administrative Director of Programs and Operations
ngrimes@cradlebeach.org / (716) 549-6307 ext. 203
2020 Respite Application

Mail Application to:
Cradle Beach
Attn: RESPITE SERVICES
8038 Old Lakeshore Rd
Angola, NY 14006

How to complete this application:
All information requested in this application is to be filled out completely even if the applicant is returning and you have submitted a completed application in the past. In sections where information requested may not apply to you, check N/A boxes. Completed applications are accepted on a first come, first serve basis. All applicants must be 8 years old or older and have a developmental disability. They must live at home with family and NOT in a group home or other situation. Applicants must live in one of the seven counties of Western New York.

Applicant Information: Please print all information clearly

Last Name: _____________________________ First Name: _____________________ Middle Initial: _____
Nickname: _____________________ Previous Name (If there is a name change): ____________________
Date of Birth: ____________ Age: _______ Gender: □ Male  □ Female
Race (Optional): □ African American □ Asian □ Bi-Racial □ Caucasian
□ Hispanic □ Native American □ Middle Eastern □ Other: _____________
Address: _______________________________ City: ___________________ State: _____ Zip: _______
County: _______________________________ Telephone Number: (_____)______________________

Have you attended Respite previously at Cradle Beach (circle one): YES or NO If so, last year attended: _____

Parent / Guardian Information: Please print all information clearly

Parent/Guardian 1:
Name: ________________________________
Cell Phone: (_____)___________________
E-mail Address: _________________________
Employer: ______________________________
Work Phone: (_____)___________________

Parent/Guardian 2:
Name: ________________________________
Cell Phone: (_____)___________________
E-mail Address: _________________________
Employer: ______________________________
Work Phone: (_____)___________________

Respite Preference

Please place a #1 next to your 1st choice, #2 next to your 2nd choice and a #3 next to your 3rd choice

- _____ February 21 – February 23
- _____ March 27 – March 29
- _____ April 17 – April 19
- _____ May 1 – May 3
- _____ May 29 – May 31
- _____ September 25 – September 27
- _____ October 9 – October 11
- _____ October 23 – October 25
- _____ November 6 – November 8
- _____ November 13 – November 15
- _____ December 4 – December 6
- _____ December 11 – December 13
Participant Name: ______________________________________________________________

**Interests:** *(PLEASE complete questions below to help staff know your participant better.)*

What does the participant like to do?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What strategies are used to manage the participant's behaviors?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What rewards work for good behavior while at respite?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What does the participant dislike to do?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What things upset the participant?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

How does he / she express anger or frustration?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**Behavioral Issues:** *(Please check all that apply) ** These behaviors DO NOT mean exclusion from Cradle Beach Camp. **

- [ ] Wanders / runs away
- [ ] Destroys property
- [ ] Non-Compliant
- [ ] Physically aggressive (ex: hits / kicks / bites / punches)
- [ ] Inappropriate language
- [ ] Hits / Kicks others
- [ ] Eats inedibles
- [ ] Self injurious
- [ ] Inappropriate sexual behaviors: [ ] to self [ ] to others
- [ ] Collects items that do not belong to them

Helpful techniques to manage these behaviors:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Does the participant have a Behavior Intervention Plan at his/her school or agency?  [ ] Yes  [ ] No. If Yes, please provide us a copy.
As the parent/guardian of ________________________________, I authorize the participant's medical information, prescriptions to be released to Cradle Beach during the time participant attends camp. I give my __________________________________________________________________________________________

(Physician’s Office) at (_______)_________________________________ , (_______) ____________________________________

or pharmacy permission to fax the participant'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 the participant'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 the participant counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the participant.

Parent / Guardian Signature: __________________________________________________________________

Date: ___________________________________
### Emergency Contact Information:

In case of emergency CBC will contact parents/guardians FIRST. If you cannot be reached, we will contact the people you list below. Please complete this entire section. 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.

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<thead>
<tr>
<th>Name</th>
<th>Phone # (___)</th>
<th>Relationship</th>
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### Agency Services:

For example: Aspire, Autism Services, SKIP, People Inc, Summit, etc.

<table>
<thead>
<tr>
<th>Agency 1 Name</th>
<th>Case Number/ TABS #:</th>
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</thead>
<tbody>
<tr>
<td>Service Coordinator/Case Manager:</td>
<td>Telephone: (___)</td>
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<td>Service Coordinator/Case Manager Email:</td>
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<tr>
<td>Agency 2 Name</td>
<td>Case Number/ TABS #:</td>
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<tr>
<td>Service Coordinator/Case Manager:</td>
<td>Telephone: (___)</td>
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<tr>
<td>Service Coordinator/Case Manager Email:</td>
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</table>

### Parent/Guardian Medical Disclaimer/Agreement

***Must be signed for participant to attend respite***

The nurses at Respite may give the participant routine medications and over the counter medications, monitor health status and provide first aid and routine care. If there is any change in the participant care or his/her medical status, I wish to be notified.

If emergency treatment is necessary, **I give permission for the participant to be brought to Oishei Children’s 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 the participant be taken to:

- [ ] Brooks Hospital
- [ ] Oishei Children’s Hospital
- [ ] ECMC
- [ ] Mercy
- [ ] Buffalo General
- [ ] Sisters of Charity Hospital

I will provide all necessary medications and supplies needed by the participant for three (3) days. However, if the participant 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 participant to Cradle Beach, the undersigned hereby releases any and all claims for injuries suffered or sustained by the participant 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 is not signed, the participant cannot be accepted**
Health Insurance Information:

**PLEASE NOTE:** We need ALL of the insurance information requested below, as well as a copy of the current insurance card of the participant. If this section is not completed, it will be returned to you causing delays in processing your application.

Health Insurance Company:_________________________ Name of Policy Holder:_________________________

Policy Number:_________________________ Group Number or Other Number:_________________________

Medicare #:_________________________ [ ] N/A       MEDICAID #: _______________________ [ ] N/A

Physical / Medical Information:

**PLEASE NOTE:** Every applicant must have had a complete physical dated within at least one (1) year prior to the date they plan to attend a Respite Weekend. Please have your physician fill out the attached physical and over the counter form and sign and date the forms. Until we receive the physical and over the counter form, applicants will be placed on a pending list. **ANY MEDICATION CHANGES AFTER PHYSICAL EXAM DATE MUST BE ACCOMPLISHED BY A CURRENT WRITTEN PRESCRIPTION FROM THE APPLICANT'S PHYSICIAN.**

Physician's Name: ________________________________________________________________

Telephone #: (____)_______________________ Fax #: (____)_____________________

Most recent or pending date of physical: ___________________________

Has the participant been hospitalized within the past three (3) years? ☐ Yes ☐ No

If yes, please explain in detail with date(s): ___________________________________________

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.

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Times Given</th>
<th>Route</th>
<th>Reason</th>
<th>PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION</th>
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</table>
**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: _______________________________

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**Allergies to Medications and Medical-Related Allergies:**

□ Allergies to Medications (please list all below):

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

□ Epilepsy / Seizures – Type of Seizure: ____________________________ Date of Last Seizure:_______________
  Frequency: _________________________   Emergency Medications : _______________________________

□ Apraxia
□ ADHD - Attention Deficit Hyperactive 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 □ Insulin Pump
□ Down Syndrome
□ Microcephaly
□ Muscular Dystrophy
□ Genetic Condition – specify: __________________________________________________________
□ GERD - Gastroesophageal reflux disease
□ Hearing Disabilities - □ Partial Hearing Loss □ Total Hearing Loss □ Cochlear Implant □ Hearing Aids
□ Heart Condition - □ Heart Defect □ Murmur □ Hypertension □ Other:____________________________
□ Hydrocephalus □ Shunt
□ Intellectual Disabilities
□ Learning Disabilities
□ Mental Health Issues - □ Adjustment Disorder □ Anxiety □ Bi-polar Disorder □ Depression
  □ Mood Disorder □ OCD - Obsessive Compulsive Disorder
□ ODD - Oppositional Defiant Disorder □ Phobia
□ PTSD - Post Traumatic Stress Disorder □ RAD - Reactive Attachment Disorder
□ Neurological - □ Tourette’s Syndrome □ Tics □ Migraines □ Other:________
□ PICA
□ Prader-Willi Syndrome
□ Rett Syndrome
□ Scoliosis
□ Sleep Apnea
□ Spina Bifida □ Shunts
□ TBI - □ Shunt
□ Williams Syndrome
□ Vision Disabilities - □ Glasses □ Contact Lenses □ Legally Blind □ Nystagmus □ Visually Impaired
□ Comments:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Ambulatory Abilities / Aids:  □ Does Not Apply

- Electric wheelchair  □ Braces  □ Cane
- Manual wheelchair  □ Crutches  □ Uses walker  □ Walks with assistance  □ Awkward Gait

Communication:
- □ Speech is easily understood
- □ Comprehends and participates in verbal conversation
- □ Responds to own name
- □ Responds to directions
- □ Can communicate daily needs
- □ Uses Gestures
- □ Uses Sign Language
- □ Uses Communication Device (please send device with participant)
- □ Uses picture exchange or communication board
- □ Other: ______________________________

Assisted Daily Living Skills:

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Needs Prompts</th>
<th>Needs Partial Assistance</th>
<th>Needs Total Assistance</th>
</tr>
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<tbody>
<tr>
<td>Showering</td>
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<tr>
<td>Teeth Care</td>
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<td>Hair Care</td>
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<td>Dressing</td>
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<td>Menstruation Care</td>
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<tr>
<td>Toileting</td>
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Comments: ____________________________________________________________________

Sleeping Needs / Information:
- □ Walks in sleep  □ Awakens during the night  □ Requires CPAP  □ Sleeps through the night

Reasons for OPWDD bed: (please be specific) ____________________________________________

Strategies to help at bedtime: (please be specific) ______________________________________

Medications for sleep, such as Melatonin, cannot be given without a prescription from the physician.

Toileting Issues / Information:

Bring to the bathroom ___ times a day ___ Wake participant up at night  how often? _______

___ Wets bed how often? ____________________________ Wears Diapers/Pull Ups (___ at night ___ all day)
(PARENTS MUST SUPPLY DIAPERS FOR THE DURATION OF THE WEEKEND SESSION).

___ Requires catheterization - every ___ hours or other: ________________________________
### Meals/Feeding

<table>
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<th></th>
<th>Independent</th>
<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
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</thead>
<tbody>
<tr>
<td>Finger foods</td>
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<tr>
<td>Uses spoon</td>
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<tr>
<td>Uses fork</td>
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<tr>
<td>Uses knife</td>
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<tr>
<td>Drinks</td>
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<tr>
<td>Cleans self</td>
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**Adaptive meals & utensils/equipment:**

- **Meals:**
  - Blended
  - Texture (ex. Smooth):
  - Size (ex. ¼”):
  - Cut up
  - Thickened

**Eating difficulties:**

- Bite reflex
- Chewing
- Unable to close mouth
- Eats slowly
- Eats to fast
- Choking
- Gagging
- Swallowing
- Drooling
- Overfills mouth

- Needs help with positioning during meals (be specific):
- Participant has a special diet (be specific):

**Adaptive meals & utensils/equipment:**

- **Meals:**
  - Blended
  - Texture (ex. Smooth):
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- Bite reflex
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- Unable to close mouth
- Eats slowly
- Eats to fast
- Choking
- Gagging
- Swallowing
- Drooling
- Overfills mouth

- Needs help with positioning during meals (be specific):
- Participant has a special diet (be specific):

**Likes:**

**Dislikes:**

Additional information on how to best assist the participant during meal & snack time:

---

### Food/Dietary Needs:

**Please note: Cradle Beach is Peanut/ Treenut Free**

**Special Dietary needs:**

- Please give details for any dietary needs/restrictions
- **Does Not Apply**

- [ ] Gluten → Please supply supplementary Gluten Casein Free products and snacks for the participant for the respite session. Please label all items with the participant’s name. We will contact you with any questions about the participant’s dietary needs.

- [ ] Casein →

- [ ] 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
*** The following documentation MUST be sent in with application***

- A completed physical dated within at least one (1) year prior to the date they plan to attend respite.
- A documented developmental disability. You or your Case Manager must submit such documentation with a first time application.
- ISP, ISP Addendum listing Cradle Beach as Respite Care Provider and RSA approval for new applicants to respite
- New Applicants to Respite must be tested for TB, within at least one (1) year prior to the Respite Weekend they plan to attend, and results proven to be negative must be forwarded to camp for our records. New Applicants must also provide the most current physical for review to evaluate for proper placement.

The participant may be part of the following activities:

| Cradle Beach Camp may use the participant's name, photograph, and video for publicity purposes. |
| _____ Yes   _____ No   _________ Parent / Guardian Initials |
| Cradle Beach Camp may use the participant's photograph to be placed in the weekend newsletter that is ONLY distributed to the respite participants. |
| _____ Yes   _____ No   _________ Parent / Guardian Initials |

Please read the following statements and sign at the bottom of the page:

* I give permission for (Agency/School) _____________________________________ to be contacted to provide information, which will help respite staff better serve us. This information will be shared with the Cradle Beach Respite staff only.

* I give permission for the Respite Nurse to administer prescription drugs, which I will send in the original container with the original label.

* I give permission for the Respite Nurse to carry out the medical protocol of Cradle Beach's standing orders on the participant, as it pertains to non-emergencies and over the counter medications.

* I release any and all claims for injuries suffered or sustained by my son/daughter in going to or coming from Respite or while at respite and consent to hospital or medical care if needed.

| -> Completed by (print name):____________________________________________________ |
| -> Signature:  ___________________________________________ Date: ________________ |
| -> Relationship to applicant:   _____________________________________________________ |
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.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>STATUS</th>
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Children with Down Syndrome C-Spine films are recommended

Results:

<table>
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<tr>
<th>Allergies</th>
<th>Reaction</th>
<th>Treatment</th>
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<tr>
<th>SYSTEM</th>
<th>WITHIN NORMAL LIMITS</th>
<th>ABNORMAL</th>
<th>REASON</th>
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<td>HEENT</td>
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<td>NECK</td>
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<td>LUNGS</td>
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<td>HEART</td>
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<td>ABDOMEN</td>
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<td>GENITALIA</td>
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<td>SPINE</td>
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<td>EXTREMITIES</td>
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<td>NEURO</td>
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<td>SKIN</td>
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MEDICATION:
• All current medications must be listed, including any over the counter medications. Please include all reasons for giving medication

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Times Given</th>
<th>Route</th>
<th>Reason</th>
<th>PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION</th>
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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
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: __________________