Cradle Beach Summer Camp
Application Instructions

*ONLINE REGISTRATION IS AVAILABLE! You’re eligible for a $15 discount on completed online applications.
Go to: https://cradlebeach.campmanagement.com/enroll. If you are a returning camper you already have an account, please follow the instructions to login to your family’s account and apply for the 2020 camp season.

Please Note:
1. Camper acceptance and placements are on a first come, first serve basis for completed application.
2. Cradle Beach will return incomplete portions of the applications to be filled out and completed.
3. Campers must be between ages 8 – 16 on the FIRST DAY of the requested session in order to attend camp.

A completed application MUST include:
- 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) - return only if applicable
  - If you receive services through ECDSS (have an “S” or “P” at the beginning of your case number), complete the ECDSS form.

Submit Separately (can be submitted via fax, mail, or email)
- Teacher/Counselor Reference Form (Green)
- Physical and Over-the-Counter Medication Forms (Yellow) – physical exam must be within 12 months of campers last day of selected camp session.

ALL physicals must be received 3 weeks prior to the campers scheduled session for them to be allowed to attend.

If you are applying for the FIRST time - you MUST submit a current physical with the application for camp session placement review. Your application will not be reviewed without a doctor's physical.

NEW
If you are applying for the first time and your child gets services through OPWDD, we must have a copy of the camper’s life plan and your care coordinator’s name, phone number and email address.

Rev. 1.3 12/2019 - NSG
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. 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.

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<th>Fee</th>
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<td>$124,999</td>
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<tr>
<td>$125,000</td>
<td>Up</td>
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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 Information: Please print all information clearly

Last Name: ______________________________________  First Name: ____________________________  M.I.: ______

Mailing Address: _________________________________________  City: _____________________  State: ___________

Zip Code:__________  Telephone Number: (____) ___________________  Date of Birth: ______________  Age: _____

Gender: [ ] Male  [ ] Female  Grade completed in 2020:_______  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 special needs 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.

Camper Information:

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<tbody>
<tr>
<td>Session 4 – August 4 – August 12, 2020 – 11-14 yrs. old</td>
<td>Session 4 – August 4 – August 12, 2020</td>
</tr>
<tr>
<td>Session 5 – August 16 – August 22, 2020 – 8-14 yrs. old</td>
<td>Session 5 – August 16 – August 22, 2020</td>
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The PC Campers are involved in a leadership program that allows teens to assist in camper activities as well as earn community service hours. Applicants will be reviewed for appropriateness to the program.

Transportation:

<table>
<thead>
<tr>
<th>Arrival</th>
<th>Departure</th>
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<tbody>
<tr>
<td>[ ] I will drive my child to camp in Angola, NY</td>
<td>[ ] I will pick up my child from camp in Angola, NY</td>
</tr>
<tr>
<td>[ ] My child will take the bus from Stanley Makowski School in Buffalo, NY to camp</td>
<td>[ ] My child will take the bus to Stanley Makowski School in Buffalo, NY from camp</td>
</tr>
<tr>
<td>will require: [ ] wheelchair accessible bus</td>
<td>will require: [ ] wheelchair accessible bus</td>
</tr>
<tr>
<td>[ ] one-on-one aide</td>
<td>[ ] one-on-one aide</td>
</tr>
</tbody>
</table>
Applicant's Name:_________________________________________________________________

**Ethnicity: (Optional)**
- □ African American
- □ Asian
- □ Bi-Racial
- □ Caucasian
- □ Hispanic
- □ Middle Eastern
- □ Native

**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**

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Age: ___</th>
<th>Relationship: __________________________</th>
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<tbody>
<tr>
<td>Name: __________________________</td>
<td>Age: ___</td>
<td>Relationship: __________________________</td>
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<tr>
<td>Name: __________________________</td>
<td>Age: ___</td>
<td>Relationship: __________________________</td>
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</tbody>
</table>

**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? □ Yes □ No  If Yes, **PLEASE** provide a copy to camp.

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

Name of Counseling Agency: __________________________________________________________

**Agency Services:** *(For Example: Aspire, Autism 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
Applicant's Name:_______________________________________________________________

**Camper Interests:** *(PLEASE complete questions below to help staff 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 while at camp?**
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**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) **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
- [ ] Self harm

**Helpful techniques to manage these behaviors:**
_______________________________________________________________________________________________

**Does your child have a: [ ] ISP - Individualized Service Plan or Life Plan [ ] BIP - Behavior Intervention Plan**

(please check all that apply) [ ] Safety Plan

**ALL PLANS MUST BE PROVIDED, IF NOT APPLICATION PROCESSING WILL BE DELAYED.**
Ambulatory Abilities/Aids (check all that apply)

Please check all that apply:
- ☐ Awkward gait
- ☐ AFO’s
- ☐ Crutches
- ☐ Wheelchair – Manual
- ☐ Walks with assistance
- ☐ SMO’s
- ☐ Walker
- ☐ Wheelchair – Electric

Additional Information:

Communication (check all that apply)

☐ Non-verbal
☐ Verbal – limited (please explain)
☐ Uses PECS / communication board
☐ Uses communication device (please send with camper)
☐ Uses sign language
☐ Uses gestures
☐ Responds to own name
☐ Understands & responds to directions
☐ Can communicate daily needs
☐ Comprehends & participates in verbal conversation

Additional information to help us better communicate with your camper:

Personal Hygiene

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
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</thead>
<tbody>
<tr>
<td>Showering</td>
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<tr>
<td>Washes hands</td>
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<tr>
<td>Dries hands</td>
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<tr>
<td>Brushes teeth</td>
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<tr>
<td>Brushes/Styles hair</td>
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<tr>
<td>Menstruation Care</td>
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Additional Information:

Dressing

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<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
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<tbody>
<tr>
<td>Shirts/Blouses</td>
<td></td>
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<tr>
<td>Pants/Shorts/Skirts</td>
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<tr>
<td>Undergarments</td>
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<tr>
<td>Bathing Suit</td>
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<tr>
<td>Buttons</td>
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<tr>
<td>Zippers</td>
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<tr>
<td>Tying Shoes</td>
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Additional information:
### Toileting

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<th></th>
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<th>Prompting</th>
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<th>Must be supervised</th>
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<tr>
<td>Overall</td>
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<tr>
<td>Urinating</td>
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<tr>
<td>Bowel Care</td>
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Bring to bathroom _____ times a day  
Wears diapers/pull-ups: □ All Day/Night  □ Overnight

ReQUIRES catheterization every ____ hours, or other: _______________________________________

Additional information: ________________________________________________________________

### Sleeping (check all that apply)

□ Does Not Apply

□ CPAP

□ Awakens during the night: How often? ______________ causes: _____________________________

□ Requires bed rails  □ Reason for bed rails (be specific): ____________________________

□ Walks in sleep  □ Wake child up at night - how often? __________  □ Wets bed - how often? ______

□ Strategies to help at bedtime: ______________________________________________________

### Meals/Feeding

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<tr>
<th></th>
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<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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<td>Drinks</td>
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<td>Cleans self</td>
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Adaptive meals & utensils/equipment:


□ Chopped - Size (ex. ¼”): ____________  □ Cut up

Eating difficulties:

□ Bite reflex  □ Chewing  □ Unable to close mouth  □ Eats slowly  □ Eats to fast

□ Choking  □ Gagging  □ Swallowing  □ Drooling  □ Overstuffs

□ Needs help with positioning during meals (be specific): ______________________________________

□ Camper has a special diet (be specific): ____________________________________________

____________________________________________________________________________________

Favorite and/or Disliked foods: _______________________________________________________

Additional information on how to best assist your camper during meal & snack time: ___________________________
**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.)

<table>
<thead>
<tr>
<th>Emergency Contact 1</th>
<th>Emergency Contact 2</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
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<tr>
<td>Relationship to Camper:</td>
<td>Relationship to Camper:</td>
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<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
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<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
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<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
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**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 prescription changes before arrival to camp must be forwarded to camp as soon as possible for review.)

<table>
<thead>
<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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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, audiotape, 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.
Authorize to release medical information:

As the parent/guardian of _________________________________, I authorize my child’s 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: ___________________________________

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)

☐ Oishei Children’s Hospital  ☐ ECMC  ☐ Mercy  ☐ Buffalo General  ☐ Other:____________________________

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:

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):

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
We are 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 is 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](https://www.cdc.gov/vaccines/vpd/mening/public/index.html).
MENINGOCOCCAL 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: ________________

Specialist Information:

Does your applicant see a specialist (neurologist, psychologist, urologist etc.)

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Please include any specialized plans and/or prescriptions you received from the specialist.

(i.e. diabetes treatment, seizures, safety)

Has the participant experienced any of the following in the past twelve months? (Check all that apply)

☐ Entered a residential treatment living facility
☐ Exited a residential treatment living facility
☐ Experience suicidal ideation
☐ Attempted suicide
☐ Had a recent traumatic event
☐ Had a recent mental health event
☐ Had a safety plan created by an agency/hospital

Any further details/comments: __________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Specialist Information:

Does your applicant see a specialist (neurologist, psychologist, urologist etc.)

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________

Name: ____________________________________________ Phone No.: ______________________
Specialty: __________________________________________________________________________
**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)

☐ No Disability / Diagnosis

☐ Epilepsy Seizures
Type of Seizure: __________________________ Date of Last Seizure: ____________

Frequency: __________________________ Emergency Medications: __________________________

Presentation: __________________________ Average Length: __________________________

☐ 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

☐ Chiari Malformation

☐ 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

☐ Conduct Disorder ☐ Depression ☐ Emotional Disturbance

☐ Mood Disorder ☐ OCD - Obsessive Compulsive Disorder

☐ ODD - Oppositional Defiant Disorder ☐ Phobia

☐ PTSD - Post Traumatic Stress Disorder ☐ RAD - Reactive Attachment Disorder

☐ Schizoaffective Disorder

☐ Neurological - ☐ Tourette’s Syndrome ☐ Tics ☐ Migraines ☐ Other: __________

☐ PICA

☐ Prader-Willi Syndrome

☐ Sleep Apnea

☐ Spina Bifida

☐ TBI - ☐ Shunt

☐ Vision Disabilities - ☐ Glasses ☐ Contact Lenses ☐ Legally Blind ☐ Nystagmus ☐ Visually Impaired

☐ Others Comments: ____________________________________________________________
Applicant's Name: ____________________________________________________________

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 ☐ ear plugs ☐ cochlear implants

Program Information:
Can Cradle Beach use your child’s name, photograph, and / or video for publicity purpose? ☐ Yes ☐ No
Can Cradle Beach post your child's photograph/video on our parent blog? ☐ Yes ☐ No
(Access to blog is only granted to parents whose children are attending the session and staff)
Cradle Beach does programming during camp to celebrate different holidays, festivals, birthdays, 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, Individualized Education Plan, Behavioral Intervention Plans, Safety Plan and Individualized 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, medical or mental health reasons. If we cannot guarantee the safety of your child or others (including staff) your child will be sent home. If your child is being sent home; they MUST be picked up within four (4) hours.

I am aware:
☐ The $30 Application fee is non-refundable
☐ Camp fees will NOT be returned if your child is sent home for behavioral reasons.
☐ Cancellation refunds for 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.
☐ If I am not able to provide a current physical 3 weeks prior to my camper's arrival date, my camper will forfeit their placement and be placed on the wait list until current physical is received. New placements will be determined based on availability.

The Application was 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>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction</th>
<th>Treatment</th>
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<th>HT:</th>
<th>WT:</th>
<th>HR:</th>
<th>BP:</th>
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<tr>
<th>SYSTEM</th>
<th>WITHIN NORMAL LIMITS</th>
<th>ABNORMAL</th>
<th>REASON</th>
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<tr>
<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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<tr>
<td>NEURO</td>
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<tr>
<td>SKIN</td>
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</table>
**MEDICATION:**

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

<table>
<thead>
<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>

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 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: ___________________
Parent/Guardians: Please fill out this top section and give it to your child’s teacher, counselor, principal, or social worker. This form should be mailed separately by your child’s reference source. Please do not wait for this form to send in your camper application.

Camper’s Name ____________________________________     Year 20______

Teacher’s Name: ______________________________________ Teacher’s Work # (____)___________________

School: ___________________________________________________

Classroom Type:   6:1:1   8:1:1   12:1:1   15:1   UG   Inclusion   General Education

Dear Teacher:

The following child is applying to attend Cradle Beach Camp. Campers stay overnight between 7-10 days.

Please complete this confidential form so our staff can assist the child to the best of our ability. Please be honest about the child’s behaviors. The child’s behaviors will not mean exclusion from Cradle Beach Camp.

You may also print a teacher form from our website at www.cradlebeach.org. From our home page, go to Summer Enrichment Program, select camp dates, choose teacher form.

Please mail, fax, or email this form to
Cradle Beach Admissions, 8038 Old Lakeshore Rd, Angola, NY 14006 or
Fax to (716) 549-6825 or
Email to admissions@cradlebeach.org

We have 3 cabin settings: Field, Hill, and Pioneer Camper (PC).

Please select the most appropriate setting for this child.

☐ Field Campers: Campers age 8-14; Children who function at grade level, have strong independent daily living skills, and will stay with the group.

☐ Hill Campers: Campers age 8-16; Children who have intensive physical and/or intellectual needs, and/or might need total assistance with daily living skills and/or possible 1:1 supervision.

☐ Pioneer Campers (PC’s): Campers ages 14-16; PC’s should have strong independent daily living skills, demonstrate responsible behavior, leadership skills and good work ethic. Youth selected as PC’s must be physically and intellectually able to perform assigned PC duties.

Thank you in advance for your assistance!
Camper's Name: 

<table>
<thead>
<tr>
<th>Place in the classroom:</th>
<th>Relationship to peers:</th>
<th>Relationship to teacher:</th>
<th>Following directions:</th>
<th>PC ages 14-16: demonstrate Leadership Skills:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader</td>
<td>Outgoing</td>
<td>Responsive</td>
<td>Cooperative</td>
<td>Role model</td>
</tr>
<tr>
<td>Independent</td>
<td>Several friends</td>
<td>Cooperative</td>
<td>Testing</td>
<td>Teamplayer</td>
</tr>
<tr>
<td>Friendly</td>
<td>One friend</td>
<td>Dependent</td>
<td>Needs adaptation</td>
<td>Self-motivated</td>
</tr>
<tr>
<td>Follower</td>
<td>Shy</td>
<td>Attention seeking</td>
<td>Resentful to authority</td>
<td>Takes initiative</td>
</tr>
<tr>
<td>Quiet</td>
<td></td>
<td>Respectful of authority</td>
<td></td>
<td>Accepts directions</td>
</tr>
</tbody>
</table>

Will the child do well in a camp setting with structured activities? Yes  No  

Will the child choose to be part of a group or individual activities? To be part of a group  To be independent  To be with a group but needs supervision  Individual activities with 1:1

What kinds of activities does the child have interest in?  

What activities cause anxiety or stress?  

Does this child demonstrate any behaviors?  

- Wanders/runs away  
- Non-compliant  
- Eats inedibles  
- Inappropriate language  
- Inappropriate sexual behaviors  
- Destroys property  
- Self-injurious behaviors  

- Hits/kicks others  
- Bites  
- Collects items that do not belong to them  
- Must be supervised when around peers  
- Self harm  
- Inappropriate social behaviors  
- Inappropriate conduct  

Does this student have a  

- Behavior Intervention Plan  
- IEP  
- 504 Plan  

Please forward copy of all applicable plans with reference letter  

Please explain any behaviors that were checked off:  

Please provide us with some strategies that will help the student be successful at camp:  

In the past year has the child been expelled? Yes  No  
Did they return to school? Yes  No  

In the past year has the child been suspended for any amount of time greater than a week? Yes  No  

Information to contact you if we need any clarifications: Name:  
Phone:  
Email:  
Title:  
Date:  

Thank you for taking the time to help us get to know this student better for a successful camp experience!
Summer Food Parent Letter

Cradle Beach Camp is participating in the Summer Food Service Program. Meals will be provided to all eligible children free of charge. (To be eligible to receive free meals at a camp, children must meet the income guidelines for reduced price meals in the National School Lunch Program). Children who are part of households that receive foods stamps or benefits under the Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible to receive free meals. The following 2019-2020 income eligibility standards will be used for determining eligibility for free meals:

### Income Eligibility Guidelines

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Year</th>
<th>Month</th>
<th>Twice per Month</th>
<th>Every Two Weeks</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$22,107</td>
<td>$1,926</td>
<td>$963</td>
<td>$889</td>
<td>$445</td>
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<tr>
<td>2</td>
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<td>$1,304</td>
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<td>$2,147</td>
<td>$1,074</td>
</tr>
<tr>
<td>6</td>
<td>$63,992</td>
<td>$5,333</td>
<td>$2,667</td>
<td>$2,462</td>
<td>$1,231</td>
</tr>
<tr>
<td>7</td>
<td>$72,169</td>
<td>$6,015</td>
<td>$3,008</td>
<td>$2,776</td>
<td>$1,388</td>
</tr>
<tr>
<td>8</td>
<td>$80,346</td>
<td>$6,696</td>
<td>$3,348</td>
<td>$3,091</td>
<td>$1,546</td>
</tr>
<tr>
<td>For each additional family member, add</td>
<td>$ 8,177</td>
<td>$ 682</td>
<td>$ 341</td>
<td>$ 315</td>
<td>$ 158</td>
</tr>
</tbody>
</table>

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.

### Camp and/or closed enrolled site information

<table>
<thead>
<tr>
<th>Session Name &amp; Date</th>
<th>Meals Available</th>
<th>Service Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: 06/29/2020 - 07/07/2020</td>
<td>Breakfast, Lunch, Dinner</td>
<td>8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM</td>
</tr>
<tr>
<td>Session 2: 07/10/2020 - 07/19/2020</td>
<td>Breakfast, Lunch, Dinner</td>
<td>8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM</td>
</tr>
<tr>
<td>Session 3: 07/22/2020 - 07/31/2020</td>
<td>Breakfast, Lunch, Dinner</td>
<td>8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM</td>
</tr>
<tr>
<td>Session 4: 08/04/2020 - 08/12/2020</td>
<td>Breakfast, Lunch, Dinner</td>
<td>8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM</td>
</tr>
<tr>
<td>Session 5: 08/16/2020 - 08/22/2020</td>
<td>Breakfast, Lunch, Dinner</td>
<td>8:00- 9:30AM, 12:15- 2:00 PM, 6:00- 7:30PM</td>
</tr>
</tbody>
</table>

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-3027) 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.

1/2/2020

(Signature of Authorized Representative) (Date)
**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:** Write FOSTER next to child’s name.  
**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 signingadult’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) 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.

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To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](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;

3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.
Part 1. Children enrolled in Camp or Closed Enrolled Sites.

<table>
<thead>
<tr>
<th>Names</th>
<th>SNAP (Food Stamp), TANF or FDPIR case # (if any). Skip to Part 4 if you listed a case #.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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 [name of Sponsor] at [phone number]. 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

<table>
<thead>
<tr>
<th>A. Name</th>
<th>B. Gross income and how often it was received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Earnings from work before deductions</td>
</tr>
<tr>
<td></td>
<td>2. Welfare, child support, alimony</td>
</tr>
<tr>
<td></td>
<td>3. Social Security, pensions, retirement,</td>
</tr>
<tr>
<td></td>
<td>4. All Other Income</td>
</tr>
<tr>
<td></td>
<td>Example: $100/monthly $100/twice a month $100/every other week $100/weekly</td>
</tr>
<tr>
<td>1.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
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<td>2.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
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<td>3.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
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<td>4.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
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<tr>
<td>5.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>6.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>7.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>8.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>9.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>10.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>11.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
<tr>
<td>12.</td>
<td>$<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em> $<em><strong>/</strong></em></td>
</tr>
</tbody>
</table>

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 ❑ Asian ❑ American Indian or Alaska Native
❑ Not Hispanic or Latino ❑ White ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American

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

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: ______________
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. You may receive notification from Erie County that your family is approved for financial coverage, that does mean they have been accepted to Cradle Beach Camp. Cradle Beach Camp Application Processing is separate from the Erie County payment process.

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 (Camp Application Packet - Page 7)
- The Medical Disclaimer and Meningococcal Meningitis Vaccination Response Form (Camp Application Packet - Page 9)
- The Permission Page (Camp Application Packet – Page 12)
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:        Persons/organizations receiving the information:

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

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)
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)
CREDIT CARD FORM FOR CAMPER’S FEES

Please Note: We can not take credit card payments over the phone you can make a payment online through your parent dashboard.

Camper’s Name: _________________________________________________________

Card Holder’s Name: _____________________________________________________________

Card Holder’s Address: ___________________________________________________________

Card Holder’s City/ State/ Zip: ______________________________________________________

Card Holder’s Telephone: (________) ________________________________________________

Credit Card:           VISA  MASTER CARD          AMERICAN EXPRESS     DISCOVER

Card # ____ ____ ____ ____ - ____ ____ ____ ____ - ___ ____ ___ ___ - ____ ____ ____ ____

Security Code (on back of card): ____ ____ ____

Exp. Date: ___________________________

Amount to be charged:  $ ______________

Card Holder Signature: __________________________________________

Please Check All that apply:

☐ Application Fee $30
☐ Auto Pay Monthly Payment (Payment will be divided up equally each month of how many months till camper comes to camp, application fee will be processed once camper is accepted)
☐ Full Payment

OFFICE ONLY

Received By: ___________________________________________ Date: ____________________

☐ Credit Card Approved

☐ Credit Card Declined

Date Declined: ________________ Date Parents Notified: ________________

☐ Notified Parents