Cradle Beach Summer Camp
Application Instructions

*ONLINE REGISTRATION IS AVAILABLE!

Go to: [https://cradlebeach.campmanagement.com/enroll](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 2022 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
- **$15 processing fee** – Check, Money Order, or Credit Card (please, no cash payments). Applications will be processed once a processing fee is received.
- **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.

*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.*
What is a Pioneer Camper (PC)?
Our Pioneer Camper (PC) Program is made up of selected young adults (ages 13 – 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. PC’s are able to earn community service hours throughout the session. A letter will be provided after the session confirming the number of hours served as well as the activities completed. PC's participate in age-appropriate programming in the evenings including an awards ceremony at the end of the session.

Fees:
Camp fees are on a sliding scale based on gross household income. Please note that any additional child(ren) are 50% off.

New this YEAR! There are scholarships and payment plans available. Scholarships are awarded based on need and availability. A scholarship application must be complete to be eligible.

**Fee Scale**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Camper</th>
<th>PC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - 0- $30,000</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Tier 2 - $30,000 - $65,000</td>
<td>$275</td>
<td>$150</td>
</tr>
<tr>
<td>Tier 3 - $65,000 - $100,000</td>
<td>$400</td>
<td>$225</td>
</tr>
<tr>
<td>Tier 4 - $100,000 - $150,000</td>
<td>$625</td>
<td>$300</td>
</tr>
<tr>
<td>Tier 5 - $150,000 and up</td>
<td>$875</td>
<td>$375</td>
</tr>
</tbody>
</table>

If you have any questions or need assistance or clarification, please feel free to contact us at Phone: (716) 549-6307 ext 205.
Email: rhackford@CradleBeach.org
**Camper Information:** Please print all information clearly

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>M.I.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>City:</th>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Zip Code:</th>
<th>Telephone Number: (____)</th>
<th>Date of Birth:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
<th>Grade completed in 2022:</th>
<th>Is the Camper:</th>
<th>New</th>
<th>Returning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District:</th>
<th>School Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent Information:** **Parent child resides with**

<table>
<thead>
<tr>
<th>Parent / Guardian 1:</th>
<th>Parent / Guardian 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Relationship to Camper:</td>
<td>Relationship to Camper:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Email Address:</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Employer:</td>
<td>Employer:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
</tr>
</tbody>
</table>

**Session Preference**

Please place a #1, #2, #3 in front of your preferred camp session date for your camper's first choice and #1, #2, #3 behind date for your second session preference.

**Session dates:**

<table>
<thead>
<tr>
<th>1st</th>
<th>2nd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1 - June 27 - July 1, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 2 - July 4 - July 8, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 3 - July 11 - July 15, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 4 - July 18 - July 22, 2022</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1st</th>
<th>2nd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 5 - July 25 - July 29, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 6 - August 1 - August 5, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 7 - August 8 - August 12, 2022</td>
<td></td>
</tr>
<tr>
<td>Session 8 - August 15 - August 19, 2022</td>
<td></td>
</tr>
</tbody>
</table>

**Transportation:**

<table>
<thead>
<tr>
<th>Arrival</th>
<th>Departure</th>
</tr>
</thead>
<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 West Buffalo Charter School in Buffalo, NY to camp will require:</td>
<td>My child will take the bus to West Buffalo Charter School in Buffalo, NY from camp will require:</td>
</tr>
<tr>
<td>wheelchair accessible bus</td>
<td>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 American

**Household Information:**
Total number of people living in your household including camper: ______
Are there any custody issues? [ ] Yes [ ] No
Who has custody or legal guardianship of the camper? __________________________________________________

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

- Name: ___________________________ Age: ___ Relationship: ___________________________
- Name: ___________________________ Age: ___ Relationship: ___________________________
- Name: ___________________________ Age: ___ Relationship: ___________________________
- Name: ___________________________ Age: ___ Relationship: ___________________________
- Name: ___________________________ Age: ___ Relationship: ___________________________
- Name: ___________________________ Age: ___ Relationship: ___________________________

**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: Person Centered Services, Prime Care, Aspire, People, Inc., 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 triggers behaviors for your child?

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

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  ☐ Inappropriate language  ☐ Self injurious
☐ Destroys property  ☐ Bites  ☐ Inappropriate sexual behaviors: ☐ to self  ☐ to others
☐ Non-Compliant  ☐ Eats inedibles  ☐ Collects items that do not belong to them
☐ Physically aggressive (ex: pinches, scratches, hits, etc)  ☐ 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.**
**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.) Emergency contacts must be over 18 years old and approved to pick-up your child.

<table>
<thead>
<tr>
<th>Emergency Contact 1</th>
<th>Emergency Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Relationship to Camper:</td>
<td>Relationship to Camper:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
</tr>
</tbody>
</table>

**Health Insurance Information:**

PLEASE NOTE: ALL insurance information requested below is required, as well as a copy of the participant's current insurance card. 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 a completed physical dated within at least one (1) year prior to the date they plan to attend summer camp. Please have your physician fill out the attached physical and over the counter form. Until we receive proof of physical and over the counter form, applicants will be placed on a pending list. ANY MEDICATION CHANGES AFTER PHYSICAL EXAM DATE MUST BE ACCOMPANIED 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): __________________________

**Specialist Information:** Please list any specialist your camper may be seen by. Please include any specialized plans and/or prescriptions you receive from the specialist. (i.e., diabetes treatment, seizures plans, safety plans, etc.)

Name: __________________________ Phone No.: __________________________

Specialty: __________________________

Name: __________________________ Phone No.: __________________________

Specialty: __________________________

Name: __________________________ Phone No.: __________________________

Specialty: __________________________
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:**

___________________________________________

___________________________________________

___________________________________________


**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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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, 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
**Important Information about Meningococcal Meningitis**

Dear Parent/Guardian:

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 7-2 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.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illness such as infection of the lining of the brain and spinal column (meningitis) or blood infection (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick.

Anyone can get meningococcal disease, but certain people are at increased risk including teens and young adults (16-23 years old) and those with certain medical conditions that affect the immune system.

**The single best way to prevent meningococcal disease is to be vaccinated.** The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause meningococcal disease in the United States. The Center for Disease Control and Prevention (CDC) recommends a single dose of MenACWY vaccine at age 11 through 12 years with a booster dose give at age 16 years. Children are not routinely recommended to receive MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes meningococcal disease. Young adults aged 16 through 23 years may be vaccinated with MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

Information about the availability and cost of meningococcal vaccine can be obtained from your health care provider or your local health department. Cradle Beach does not offer meningococcal immunization services.

Cradle Beach is required to maintain a record for each camper, signed by the camper's parent or guardian, which documents the following:

- Receipt and review of meningococcal disease and vaccine information;
  AND EITHER
- Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
- An understanding of meningococcal disease risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

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).

Sincerely,

Gabriele Clark
Director of Campus Based Services
Cradle Beach
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.  
(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.)  Date received: ____________________________

☐ 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: ____________________

Parent Organizer 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 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 for my 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: ______________________________________________________________________________ Date: ____________________

Print Name: ______________________________________________________________________________ Date: ____________________

Authorize to release medical information:

As the parent/guardian of ____________________________________________, I authorize my child’s medical information,  
(Applicant’s name)
prescriptions to be release to Cradle Beach during the time my child attends camp. I give my

__________________________________________________________  (Physician’s Office)

at (_____)___________________________, (_____)___________________________ 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 condition 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: ____________________
Applicant's Name: ____________________________________________________________

**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** □
  
  While we have some gluten and casein free meals and products, we ask that any special brands or unique items that the camper prefers be provided. All items will be labeled and checked in with our kitchen.

- **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: __________________________

***Please provide Cradle Beach with a seizure plan***

☐ ADHD - Attention Deficit Hyperactivity Disorder

☐ APD – Auditory Processing Disorder

☐ Apraxia of ______________________________

☐ 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 Uses: ☐ Insulin Pump ***Please provide diabetic plan***

☐ Down Syndrome

☐ Genetic Condition – specify: ______________________________________________________________________

☐ GERD - Gastroesophageal reflux disease

☐ Microcephaly

☐ Muscular Dystrophy

☐ Hearing Disabilities - ☐ Partial Hearing Loss ☐ Total Hearing Loss Uses: ☐ Cochlear Implant ☐ Hearing Aids

☐ Heart Condition - ☐ Heart Defect ☐ Murmur ☐ Hypertension ☐ Other: ______________________________

☐ Hydrocephalus

☐ Intellectual Disabilities

☐ Learning Disabilities

☐ Mental Health Issues - ☐ Adjustment Disorder ☐ Anxiety ☐ Bi-polar Disorder

☐ CPTSD- Complex Post-Traumatic Stress 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 ☐ Shunt- Type __________________________

☐ PICA

☐ Prader-Willi Syndrome

☐ Sleep Apnea

☐ Spina Bifida

☐ TBI

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

☐ Others

Comments:__________________________________________________________________________________________
**Ambulatory Abilities/Aids (check all that apply)**

Please check all that apply:

- [ ] Awkward gait
- [ ] AFO’s
- [ ] Crutches
- [ ] Walks with assistance
- [ ] SMO’s
- [ ] Walker
- [ ] Wheelchair – Manual
- [ ] Wheelchair – Electric

**Communication (check all that apply)**

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

**Personal Hygiene**

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

**Dressing**

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirts/Blouses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pants/Shorts/Skirts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergarments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing Suit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buttons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zippers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tying Shoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information:**

- [ ] Additional Information:
- [ ] Additional Information to help us better communicate with your camper:
- [ ] Additional Information:
- [ ] Additional information: 
### Toileting

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
<th>Must be supervised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bring to bathroom _____ times a day  
Wears briefs/pull-ups:  
- All Day/Night  
- Overnight  

**Requires catherization** every ____ hours, or other: __________________________

Additional information: ____________________________________________________________

### Sleeping (check all that apply)  
☐ Does Not Apply

- Uses 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

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Prompting</th>
<th>Some Help</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finger foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses spoon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses fork</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses knife</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleans self</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Adaptive meals & utensils/equipment:**

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

**Eating difficulties:**

- Bite reflex  
- Chewing  
- Pockets Food  
- Eats slowly  
- Eats too fast  
- 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: ________________________________
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

Program Information:
Can Cradle Beach use your child’s name, photograph, and / or video for publicity purposes? □ 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 two (2) hours.

I am aware:
□ The $15 processing 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: _________________________________________________________
Cradle Beach
where children’s spirits soar
since 1889

Physical Form

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children with Down Syndrome C-Spine films are recommended.

Results: __________________________________________

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HT:</th>
<th>WT:</th>
<th>HR:</th>
<th>BP:</th>
<th>RR:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>WITHIN NORMAL LIMITS</th>
<th>ABNORMAL</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NECK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUNGS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABDOMEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENITALIA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPINE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXTREMITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEURO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION**

Can this child go into a life guard supervised pool?  
☐ Yes  ☐ Yes – with 1-on-1 supervision/assistance  ☐ 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:_____________________

Camper’s Name:________________________________DOB:_______________ Date of Exam:_______________
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: _____________________________________________ Teacher’s Email ______________________________

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 for 5 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 may have high physical, intellectual needs, and/or mental health needs and/or might need total assistance with daily living skills and/or possible 1:1 supervision.

☐ Pioneer Campers (PC's): Campers ages 13-16; 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 13-16: 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 (if no please explain):

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  [ ] Hits/kicks others
[ ] Non-compliant     [ ] Bites self
[ ] Eats inedibles    [ ] Bites others
[ ] Inappropriate language [ ] Collects items that do not belong to them
[ ] Inappropriate sexual behaviors [ ] Must be supervised when around peers
[ ] Destroys property  [ ] Self harm
[ ] Self-injurious behaviors  [ ] Inappropriate social behaviors

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 suspended for any amount of time greater than a week?  [ ] Yes  [ ] No
If Yes, please explain:

In the past year has the child been expelled?  [ ] Yes  [ ] No
Did they return to school?  [ ] 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!
Cradle Beach, Inc. 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 2021-2022 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>$23,828</td>
<td>$1,986</td>
<td>$993</td>
<td>$917</td>
<td>$459</td>
</tr>
<tr>
<td>2</td>
<td>$32,227</td>
<td>$2,686</td>
<td>$1,343</td>
<td>$1,240</td>
<td>$620</td>
</tr>
<tr>
<td>3</td>
<td>$40,626</td>
<td>$3,386</td>
<td>$1,693</td>
<td>$1,563</td>
<td>$782</td>
</tr>
<tr>
<td>4</td>
<td>$49,025</td>
<td>$4,086</td>
<td>$2,043</td>
<td>$1,886</td>
<td>$943</td>
</tr>
<tr>
<td>5</td>
<td>$57,424</td>
<td>$4,786</td>
<td>$2,393</td>
<td>$2,209</td>
<td>$1,105</td>
</tr>
<tr>
<td>6</td>
<td>$65,823</td>
<td>$5,486</td>
<td>$2,743</td>
<td>$2,532</td>
<td>$1,266</td>
</tr>
<tr>
<td>7</td>
<td>$74,222</td>
<td>$6,186</td>
<td>$3,093</td>
<td>$2,855</td>
<td>$1,428</td>
</tr>
<tr>
<td>8</td>
<td>$82,621</td>
<td>$6,886</td>
<td>$3,443</td>
<td>$3,178</td>
<td>$1,589</td>
</tr>
</tbody>
</table>

For each additional family member, add $8,399 $700 $350 $324 $162

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: 06/27/2022 - 07/01/2022</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: 07/04/2022 - 07/08/2022</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: 07/11/2022 - 07/15/2022</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: 07/18/2022 - 07/22/2022</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: 07/25/2022 - 07/29/2022</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 6: 08/01/2022 - 08/05/2022</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 7: 08/08/2022 - 08/12/2022</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 8: 08/15/2022 - 08/19/2022</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.

(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 signing adult’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.

- **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).
- **Box 2:** List the amount each person got last month from welfare, child support, alimony.
- **Box 3:** List Social Security, pensions, and retirement.
- **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) case number for your child or other (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.

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.

To file a program complaint of discrimination, complete the **USDA Program Discrimination Complaint Form**, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint_filing_cust.html](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; or

3. email: program.intake@usda.gov

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

Names
(First, Middle Initial, Last)

SNAP (Food Stamp), TANF or FDPIR case # (if any). Skip to Part 4 if you listed a case #.

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 Cradle Beach Camp at (716) 549-6307 ext. 205. 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

A. Name
(List everyone in household, including children)

B. Gross income and how often it was received
Example: $100/monthly $100/twice a month $100/every other week $100/weekly

1. $______/________ $______/_______ $______/_______ $______/_______

2. $______/________ $______/_______ $______/_______ $______/_______

3. $______/________ $______/_______ $______/_______ $______/_______

4. $______/________ $______/_______ $______/_______ $______/_______

5. $______/________ $______/_______ $______/_______ $______/_______

6. $______/________ $______/_______ $______/_______ $______/_______

7. $______/________ $______/_______ $______/_______ $______/_______

8. $______/________ $______/_______ $______/_______ $______/_______

9. $______/________ $______/_______ $______/_______ $______/_______

10. $______/________ $______/_______ $______/_______ $______/_______

11. $______/________ $______/_______ $______/_______ $______/_______

12. $______/________ $______/_______ $______/_______ $______/_______

C. Check if NO income

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

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

Total Income: ____________

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

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 not 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)
AUTHORIZATION FOR RELEASE OF INFORMATION
BY THE ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

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             Summer Camps- for the purpose of determination of eligibility for ECDSS Summer Camp Program (to pay camper’s fees up to allowable amount).
95 Franklin Street
Buffalo, New York 14202

CAMP NAME:    CRADLE BEACH, Inc.

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


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

Exp. Date: ___________________________

Amount to be charged: $ ______________

Card Holder Signature: __________________________________________

Please Check All that apply:

□ Processing Fee $15

□ Auto Pay Monthly Payment (Payment will be divided up equally each month until camper is scheduled to attend camp.)

□ Full Payment

OFFICE ONLY

Received By: ____________________________________________ Date: ______________________

□ Credit Card Approved

□ Credit Card Declined
Date Declined: _____________

□ Notified Parents
Date Parents Notified: _____________