Dear Respite Parents and Agency Representatives,

The purpose of our Respite Program is to provide relief for family caregivers who's daily tasks include caring for a loved one with disabilities. We will utilize our 66 acre campus and the skills of our trained staff and registered nurses to provide this service. Participants may attend one Respite weekend per year. Cradle Beach is a Home & Community Based Medicaid Waiver Program under OPWDD guidelines; there is no out of pocket expense for parents/guardians.

**Respite Weekends 2022**

<table>
<thead>
<tr>
<th>Month</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>28th-30th</td>
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<tr>
<td>February</td>
<td>11th-13th</td>
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<tr>
<td>March</td>
<td>4th-6th</td>
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<td>March</td>
<td>18th-20th</td>
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<tr>
<td>April</td>
<td>1st-3rd</td>
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<tr>
<td>April</td>
<td>29th-May 1st</td>
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<td>May</td>
<td>13th-15th</td>
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<td>May</td>
<td>20th - 22nd</td>
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<td>September</td>
<td>23rd-25th</td>
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<td>September</td>
<td>30th - Oct 1st</td>
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<td>October</td>
<td>14th-16th</td>
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<td>October</td>
<td>28th-30th</td>
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<td>November</td>
<td>11th-13th</td>
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<td>November</td>
<td>18th-20th</td>
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<tr>
<td>December</td>
<td>2nd-4th</td>
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<tr>
<td>December</td>
<td>16th-18th</td>
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</table>

**Criteria for Respite Program:**

- Participant must be 8 years of age or older and have a documented developmental disability.
- Participant must live at home with family or legal guardian. Individuals living in group homes or other residential facility do not qualify for this program.
- Participant must live in one of the seven counties of Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans.)
- Participants must have a physical examination and physician approved Over the Counter Medication Form (OTC Form) within a year of their Respite weekend.

**OPWDD guidelines require specific documentation in order to participate in the Respite Program:**

If applicant is new to the Cradle Beach Respite Program they MUST have:

- Documented negative TB test occurring within a year of their Respite weekend
- Request for Service Amendment (RSA)
- Front Door Policy
- Individual Service Plan (ISP)
- ISP addendum requesting Cradle Beach as a Respite Provider

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

Applications will be evaluated for placement on a first come, first served basis. If you need to cancel, PLEASE contact as soon as possible. All rescheduling will be based on availability. If you have any questions, please feel free to contact us at (716) 549-6307 ext. 205 or at admissions@cradlebeach.org. Once again, we look forward to providing you with our Respite services.
2022 Respite Application

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

How to complete this application:

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

Applicant Information: Please print all information clearly

Last Name: _____________________________ First Name: _____________________ Middle Initial: _____
Nickname: _____________________________ Previous Name (If there is a name change): __________________
Date of Birth: ____________ Age: ______ Gender: [ ] Male  [ ] Female

Race (Optional):  [ ] African American  [ ] Asian  [ ] Bi-Racial  [ ] Caucasian
[ ] Hispanic  [ ] Native American  [ ] Middle Eastern  [ ] Other: _______________________

Address: __________________________________ City: __________________ State: _____ Zip: _________
County: __________________________________ Telephone Number: (_____)____________________

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

Parent / Guardian Information: Please print all information clearly

Parent/Guardian 1: Parent/Guardian 2:

Name: ________________________________ Name: ________________________________

Cell Phone: (_____)__________________ Cell Phone: (_____)__________________

E-mail Address: _______________________ E-mail Address: ______________________

Employer: ___________________________ Employer: ___________________________

Work Phone: (_____)__________________ Work Phone: (_____)__________________

Respite Date Preferences: Please place a #1, #2, #3 in front of date for your first session and #1, #2, #3 behind date for your second session preferences.

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<tbody>
<tr>
<td>January 28th-30th</td>
<td>April 1st-3rd</td>
<td>April 1st-3rd</td>
<td>April 29th-May 1st</td>
<td>Sept 23rd-25th</td>
<td>Sept 30th - Oct 1st</td>
<td>Nov 11th-13th</td>
<td>Nov 18th-20th</td>
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<td>May 13th-15th</td>
<td>Sept 29th-10th</td>
<td>October 14th-16th</td>
<td>Nov 18th-20th</td>
<td>Dec 2nd-4th</td>
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<td>March 4th-6th</td>
<td>April 1st-3rd</td>
<td>May 13th-15th</td>
<td>May 20th - 22nd</td>
<td>October 28th-30th</td>
<td>Oct 28th-30th</td>
<td>Dec 16th-18th</td>
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<td>March 8th-20th</td>
<td>April 1st-3rd</td>
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<td>Oct 28th-30th</td>
<td>Oct 28th-30th</td>
<td>Oct 28th-30th</td>
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</table>
Interests: (PLEASE complete questions below to help staff know your participant better.)

What does the participant like to do?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

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

What rewards work best for good behavior while at Respite?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What does the participant dislike to do?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What things upset the participant?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

_How do they (the participant) express anger or frustration?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Behavioral Issues: (Please check all that apply) *These behaviors will not exclude participants from Cradle Beach Camp.*

- □ Wanders / Runs away
- □ Destroys Property
- □ Non-Compliant
- □ Inappropriate Language
- □ Bites others/self
- □ Eats Inedible Objects
- □ Self Harm/Injury
- □ Inappropriate sexual behaviors: □ To Self □ To Others
- □ Collects items that do not belong to them
- □ Physically aggressive (ex: hits / kicks)

Helpful techniques to manage these behaviors:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

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

__________________________________________________________________________________________

(Physician’s Office) at (_______)________________________________ , (_______) _______________________________________

I give this Physician (listed above) or pharmacy permission to fax the participant's physical and/or prescriptions to Cradle Beach at (716) 549-6825. I authorize any physician, nurse, or health care provider, to communicate with the medical staff and Director of Campus Based Services at Cradle Beach about the participant's medical condition treatment and/or prognosis. I further authorize the medical staff at Cradle Beach to discuss any medical conditions with the Director of Campus Based Services, his/her designee, or the participant's counselor when the medical staff, believes such communication will be in the best interest of the participant.

Parent / Guardian Signature: __________________________________________________________________

Date: ________________________________

Household Information:

Total number of people living in your household including participant: ____

Are there any custody issues? □ No □ Yes

Who has custody or legal guardianship of the participant? __________________________________________________________________

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

Name: ___________________________ Age: ___ Relationship: ___________________________

Name: ___________________________ Age: ___ Relationship: ___________________________

Name: ___________________________ Age: ___ Relationship: ___________________________

Name: ___________________________ Age: ___ Relationship: ___________________________

Name: ___________________________ Age: ___ Relationship: ___________________________

Name: ___________________________ Age: ___ Relationship: ___________________________

Authorize to release medical information:

As the parent/guardian of ________________________________, I authorize the participant's medical information and prescriptions to be released to Cradle Beach during the time participant attends Respite.

(Physician’s Office)

at (_______)________________________________ , (_______) _______________________________________

phone #       fax #

I give this Physician (listed above) or pharmacy permission to fax the participant's physical and/or prescriptions to Cradle Beach at (716) 549-6825. I authorize any physician, nurse, or health care provider, to communicate with the medical staff and Director of Campus Based Services at Cradle Beach about the participant's medical condition treatment and/or prognosis. I further authorize the medical staff at Cradle Beach to discuss any medical conditions with the Director of Campus Based Services, his/her designee, or the participant's counselor when the medical staff, believes such communication will be in the best interest of the participant.

Parent / Guardian Signature: __________________________________________________________________

Date: ________________________________
Emergency Contact Information:

In case of emergency Cradle Beach staff will contact parents/guardians FIRST. If you cannot be reached, the Emergency Contacts listed below will be contacted. Please complete this entire section. Provide two (2) contact names (relatives, friends, etc.) other than yourself to contact in case of an emergency. Please include their phone number and relationship to you.

Name: _______________________  Phone# (_____)__________  Relationship: __________________

Name: _______________________  Phone# (_____)__________  Relationship: __________________

Agency Services:

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

Agency 1 Name: __________________________  Case Number/ TABS #: __________________
Service Coordinator/Case Manager: __________________________  Telephone: (_____)_________________
Service Coordinator/Case Manager Email: __________________________

Agency 2 Name: __________________________  Case Number/ TABS #: __________________
Service Coordinator/Case Manager: __________________________  Telephone: (_____)_________________
Service Coordinator/Case Manager Email: __________________________

Parent/Guardian Medical Disclaimer Agreement

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

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

If emergency treatment is necessary, I give permission for the participant to be brought to John R. Oishei Children's Hospital or the nearest emergency room by ambulance or staff transport for treatment. I authorize staff to release all records necessary for insurance purposes so that my insurance company can be billed for the visit, lab tests, and/or x-rays if necessary.

If time and circumstances permit, I would prefer that the participant be taken to:  □ Brooks Memorial Hospital  
□ Oishei Children's Hospital  □ ECMC  □ Mercy  □ Buffalo General  □ Sisters of Charity Hospital

I will provide all necessary medications and supplies needed by the participant for three (3) days. However, if the participant requires any additional prescription medication, I give the medical staff at Cradle Beach permission to obtain and bill me for this medication/supply after my notification. Cradle Beach will bill you directly if there is no medical insurance. In consideration of admission of this participant to Cradle Beach, the undersigned hereby releases any and all claims for injuries sustained by the participant in going to or coming from Cradle Beach, or while at Cradle Beach and consents to hospital or medical care if needed.

-> Parent/Guardian Signature: __________________________________________
-> Print Name: __________________________________________  Date: ______________

**If this is not signed, the participant cannot be accepted**
**Health Insurance Information:**

*PLEASE NOTE: 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 completed a physical dated within at least one (1) year prior to the date they plan to attend a Respite Weekend. Please have your physician fill out the attached physical and over the counter form. 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): __________________________

**Present Medications:** Must match physician/practitioner orders for medication

→ NYS law requires *all medication including Over the Counter Medication* to be dispensed only by physician’s / practitioner’s orders.

→ Please include all medications, inhalers with frequency and/or nebulizer treatments.

→ Any changes prior to arrival must be accompanied with current prescription.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Times Given</th>
<th>Route</th>
<th>Reason</th>
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**PLEASE LIST ANY SPECIAL WAYS TO ADMINISTER THE MEDICATION**
Allergy Information:  □ Does Not Apply

General Allergies:

□ Dust (please specify):______________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

□ Mold (please specify): ____________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

□ Insect (please specify): __________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

□ Animal (please specify): __________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

□ Seasonal (please specify): ________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

□ Other (please specify): ___________________________________________________________
   Reaction: ____________________________ Treatment: _______________________________

Allergies to Medications and Medical-Related Allergies:

□ Allergies to Medications (please list all below):
   Medication: __________________ Reaction: __________________ Treatment: ______________
   Medication: __________________ Reaction: __________________ Treatment: ______________
   Medication: __________________ Reaction: __________________ Treatment: ______________
   Medication: __________________ Reaction: __________________ Treatment: ______________

□ Latex Allergy
   Reaction: ____________________________ Treatment: _______________________________

□ Sunscreen or PABA Allergy
   Reaction: ____________________________ Treatment: _______________________________

□ Allergies to Food: (For example: lactose, dye allergy, specific food)
   Food: __________________ Reaction: __________________ Treatment: ______________
   Food: __________________ Reaction: __________________ Treatment: ______________
   Food: __________________ Reaction: __________________ Treatment: ______________
   Food: __________________ Reaction: __________________ Treatment: ______________
Disability / Diagnosis: (Check all that apply)

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

- [ ] Apraxia
- [ ] ADHD - Attention Deficit Hyperactive Disorder
- [ ] APD – Auditory Processing Disorder
- [ ] Asthma - [ ] Allergic Rhinitis  [ ] Exercise Induced  [ ] Other: _______________________________
- [ ] Autism – [ ] Level 1  [ ] Level 2  [ ] Level 3  [ ] Other: _______________________________
- [ ] Celiac Disease
- [ ] Cerebral Palsy
- [ ] Diabetes  [ ] Type 1  [ ] Type 2  [ ] Pre-diabetic  [ ] Insulin Pump
- [ ] Down Syndrome
- [ ] Microcephaly
- [ ] Muscular Dystrophy
- [ ] Genetic Condition – specify: ____________________________________________________________________
- [ ] GERD - Gastroesophageal reflux disease
- [ ] Hearing Disabilities - [ ] Partial Hearing Loss  [ ] Total Hearing Loss  [ ] Cochlear Implant  [ ] Hearing Aids
- [ ] Heart Condition - [ ] Heart Defect  [ ] Murmur  [ ] Hypertension  [ ] Other: _______________________________
- [ ] Hydrocephalus  [ ] Shunt
- [ ] Intellectual Disabilities
- [ ] Learning Disabilities
- [ ] Mental Health Issues - [ ] Adjustment Disorder  [ ] Anxiety  [ ] Bi-polar Disorder  [ ] Depression
  - [ ] Mood Disorder  [ ] OCD - Obsessive Compulsive Disorder
  - [ ] ODD - Oppositional Defiant Disorder  [ ] Phobia
  - [ ] PTSD - Post Traumatic Stress Disorder  [ ] RAD - Reactive Attachment Disorder

- [ ] Neurological - [ ] Tourette’s Syndrome  [ ] Tics  [ ] Migraines  [ ] Other: _______
- [ ] PICA
- [ ] Prader-Willi Syndrome
- [ ] Rett Syndrome
- [ ] Scoliosis
- [ ] Sleep Apnea
- [ ] Spina Bifida  [ ] Shunts
- [ ] TBI - [ ] Shunt
- [ ] Williams Syndrome
- [ ] Vision Disabilities - [ ] Glasses  [ ] Contact Lenses  [ ] Legally Blind  [ ] Nystagmus  [ ] Visually Impaired

Comments:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Ambulatory Abilities / Aids: ☐ Does Not Apply
☐ Electric wheelchair  ☐ Braces  ☐ Cane  ☐ Walks with assistance
☐ Manual wheelchair  ☐ Crutches  ☐ Walker  ☐ Awkward Gait

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

Assisted Daily Living Skills:

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Needs Prompts</th>
<th>Needs Partial Assistance</th>
<th>Needs Total Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showering</td>
<td></td>
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<tr>
<td>Dental Hygiene</td>
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<td>Hair Care</td>
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<tr>
<td>Dressing</td>
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<tr>
<td>Menstruation Care</td>
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<tr>
<td>Toileting</td>
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</table>

Comments: ____________________________________________________________

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

Reasons for OPWDD bed: (please be specific) ____________________________________________________________

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

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

Toileting Issues / Information:

Bring to the bathroom ___ times a day  Wake participant up at night____  how often? ____

Wets bed _____ how often? _____  Wears Diapers/Pull Ups_____ (____at night __all day)

(PARENTS/GUARDIANS MUST SUPPLY DIAPERS FOR THE DURATION OF THE WEEKEND SESSION)

____ Requires catheterization - every ____ hours or other: ____________
### Meals/Feeding

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

**Adapted meals & utensils/equipment:**

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

**Eating difficulties:**

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

- Needs help with positioning during meals (be specific):

- Participant has a special diet (be specific):

**Likes:**

**Dislikes:**

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

---

### Food/Dietary Needs:

**Special Dietary Needs:** Please give details for any dietary needs/restrictions  

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

- **Casein** →

- **Diabetic** (Parents must provide suggested carb counting/ substitutions provided by your physician/practitioner or dietary specialist)

- **Lactose Intolerant**

- **Vegetarian**

- **Food Restrictions**

- **Low Calorie**

**Is Portion Control needed?**  

- **Yes**  
- **No**
*** The following documentation MUST be sent in with application***

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

The participant may be part of the following activities:

Cradle Beach Camp may use the participant's name, photograph, and video for publicity purposes.

- _____ Yes  _____ No  ___________ Parent / Guardian Initials

Cradle Beach Camp may use the participant's photograph to be placed in the weekend newsletter that is ONLY distributed to the respite participants.

- _____ Yes  _____ No  ___________ Parent / Guardian Initials

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

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

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

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

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

- -> Completed by (print name):____________________________________________________
- -> Signature: ______________________________________ Date: ________________
- -> Relationship to applicant: _____________________________________________________
Participant's Name:_______________________________________ DOB: ____________

Date of Exam:___________

Physician’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.

Participant’s physical exam must be within 12 months of the end date of their selected Respite session.

<table>
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<th>DIAGNOSIS</th>
<th>STATUS</th>
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Participant’s 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>WT:</th>
<th>HR:</th>
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<th>SYSTEM</th>
<th>WITHIN NORMAL LIMITS</th>
<th>ABNORMAL</th>
<th>REASON</th>
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<tbody>
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<td>NECK</td>
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<td>LUNGS</td>
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<td>ABDOMEN</td>
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<td>EXTREMITIES</td>
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<td>NEURO</td>
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<td>SKIN</td>
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</table>
**MEDICATION:**

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

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<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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Can this participant go into a life guard supervised pool?  
☐ Yes ☐ Yes – with 1-on-1 supervision ☐ No If No, please explain:________________________________________________________________________

Is the participant diagnosed with Seizures?  ☐ Yes ☐ No  Type:___________________
Date of Last Seizure:_____________

Does the participants 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
Participant's Name:________________________________DOB:___________________  
Date of Exam:____________________

Over the Counter Medication Form (OTC)

Your physician/practitioner must complete this form. If we do not receive this form your 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:_____________________

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