Cradle Beach Summer Camp
Application Instructions

*ONLINE REGISTRATION IS AVAILABLE!*

Go to: [https://cradlebeach.camplink.com/enroll](https://cradlebeach.camplink.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 2023 camp season.

Any balance from 2022 or previous summer must be paid before enrollment will be considered for 2023.

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.

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

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<thead>
<tr>
<th></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 / PC Application 2023

Camper Information: Please print all information clearly
Last Name: ____________________________ First Name: ____________________________ M.I.: ______

Mailing Address: ____________________________ City: ____________________________ State: ____________
Zip Code: ________ Telephone Number: (____) ___________________ Date of Birth: ______________ Age: ______
Gender: □ Male □ Female □ Prefer to not respond
Grade completed in 2022: ______
Is the Camper: □ New or □ Returning
School District: ____________________________
School Name: ____________________________

Parent Information: **Parent child resides with**

Parent / Guardian 1:
Name: ____________________________ Relationship to Camper: ______
Cell Phone: ____________________________ Email Address: ____________________________
Employer: ____________________________ Work Phone: ____________________________

Parent / Guardian 2:
Name: ____________________________ Relationship to Camper: ______
Cell Phone: ____________________________ Email Address: ____________________________
Employer: ____________________________ Work Phone: ____________________________

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></th>
<th>1st</th>
<th>2nd</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Session 1 - June 26 - June 30, 2023</td>
<td>Session 2 - July 3 - July 7, 2023</td>
</tr>
<tr>
<td></td>
<td>Session 2 - July 3 - July 7, 2023</td>
<td>Session 3 - July 10 - July 14, 2023</td>
</tr>
<tr>
<td></td>
<td>Session 3 - July 10 - July 14, 2023</td>
<td>Session 4 - July 17 - July 21, 2023</td>
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<tr>
<td></td>
<td>Session 4 - July 17 - July 21, 2023</td>
<td>Session 5 - July 24 - July 28, 2023</td>
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<tr>
<td></td>
<td>Session 5 - July 24 - July 28, 2023</td>
<td>Session 6 - July 31 - August 4, 2023</td>
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<tr>
<td></td>
<td>Session 6 - July 31 - August 4, 2023</td>
<td>Session 7 - August 7 - August 11, 2023</td>
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<tr>
<td></td>
<td>Session 7 - August 7 - August 11, 2023</td>
<td>Session 8 - August 14 - August 18, 2023</td>
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</tbody>
</table>

Transportation:

<table>
<thead>
<tr>
<th></th>
<th>Arrival</th>
<th>Departure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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></td>
<td>□ My child will take the bus from West Buffalo Charter School in Buffalo, NY to camp will require: □ wheelchair accessible bus</td>
<td>□ My child will take the bus to West Buffalo Charter School in Buffalo, NY from camp will require: □ wheelchair accessible bus</td>
</tr>
<tr>
<td></td>
<td>□ one-on-one aide</td>
<td>□ one-on-one aide</td>
</tr>
</tbody>
</table>
Applicant's Name: ____________________________________________________________

**Race: (Optional)**

- [ ] African American or Black  - [ ] Asian  - [ ] 2+ Races  - [ ] Caucasian/White  - [ ] Middle Eastern
- [ ] Native American or Alaskan Native  - [ ] Native Hawaiian or Pacific Islander

**Ethnicity: (Optional)**

- [ ] Hispanic  - [ ] Non-Hispanic

**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**

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

**Education:**

**Classroom Type:**


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:**

**Agency:**[ ] Person Centered Services  [ ] Prime Care  [ ] Check box if does not apply

Agency 1 Name: ___________________________  TABS #: ___________________________

Care Coordinator / Manager Name: __________________________________________________

Telephone: (____)__________________  CC / CM Email: __________________________________________

**If Self Directed:**

Fiscal Intermediary Agency: __________________________________________________

Fiscal Intermediary Contact Name: ___________________________  Telephone: (____)________________

Fiscal Intermediary 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:  [ ] in Foster Care  [ ] in 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
- [ ] Destroys property
- [ ] Non-Compliant
- [ ] Physically aggressive (ex: pinches, scratches, hits, etc)
- [ ] Inappropriate language
- [ ] Bites
- [ ] Eats inedibles
- [ ] Self injurious
- [ ] Inappropriate sexual behaviors: [ ] to self [ ] to others
- [ ] Collects items that do not belong to them
- [ ] Self harm

Helpful Techniques to manage these behaviors:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Does your child have a: [ ] ISP - Individualized Service Plan or Life Plan [ ] BIP - Behavior Intervention Plan (please check all that apply) [ ] Safety Plan

**ALL PLANS MUST BE PROVIDED, IF NOT APPLICATION PROCESSING WILL BE DELAYED.**
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>
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<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
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<tr>
<td>Relationship to Camper:</td>
<td>Relationship to Camper:</td>
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<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
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<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
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<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
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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.*

<table>
<thead>
<tr>
<th>Health Insurance Company:</th>
<th>Name of Policy Holder:</th>
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<tbody>
<tr>
<td>Policy Number:</td>
<td>Group Number or Other Number:</td>
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<tr>
<td>Medicare #:</td>
<td>MEDICAID #:</td>
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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.**

<table>
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<th>Physician's Name:</th>
<th>Telephone #:</th>
<th>Fax #:</th>
<th>Most recent or pending date of physical:</th>
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<tbody>
<tr>
<td>Pharmacy Name:</td>
<td>Pharmacy Phone Number:</td>
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Has the participant been hospitalized within the past three (3) years? _____ Yes _____ No

If yes, please explain in detail with date(s): ________________________________
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>
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In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender. New York State public law has been amended to require that the following information be included on this camper application:

1. Cradle Beach is required to be licensed by the New York State Dept. of Health.
2. Cradle Beach is required to be inspected twice yearly.
3. Inspection reports concerning camp are on file at the Erie County Dept. of Health, Rath Building, Buffalo, NY.
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:______________________________________________

Name:_________________________________________ Phone No.:__________________________

Specialty:______________________________________________

Parent Guardian Medical Disclaimer Agreement

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

If emergency treatment is necessary, I give permission for my child to be brought to 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: ______________________________________________________________________________

Print Name:_________________________ Date:___________________________

Authorize to release medical information:

As the parent/guardian of _____________________________________________, (Applicant’s name), I authorize my child’s medical information, 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: ___________________________
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:________________________________________________________________________________
Applicant's Name:_______________________________________________________________

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

Please check all that apply:
- [ ] Awkward gait
- [ ] AFO's
- [ ] Crutches
- [ ] Wheelchair – Manual
- [ ] Walks with assistance
- [ ] SMO's
- [ ] Walker
- [ ] Wheelchair – Electric
- [ ] Does Not Apply

Additional Information:

**Communication: (check all that apply)**

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

Additional information to help us better communicate with your camper:

**Assisted Daily Living Skills:**

<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>
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<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>
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<tr>
<td>Brushes/Styles hair</td>
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<tr>
<td>Menstruation Care</td>
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<tr>
<td>[ ] N/A</td>
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</table>

Additional Information:

**Dressing:**

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

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>
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</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>
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<tr>
<td>Cleans self</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Adaptive meals & utensils/equipment:**

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

**Eating difficulties:**

- □ Bite reflex  □ Chewing  □ Pockets Food  □ Eats slowly  □ Eats too fast
- □ Choking  □ Gagging  □ Swallowing  □ Drooling  □ Overstuffs

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

- □ Camper has a special diet (be specific): ________________________________

---

**Favorite and/or Disliked foods:**

Additional information on how to best assist your camper during meal & snack time: ________________________________
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: _______________________________________________________________________________
Camper’s Name:_______________________________________ DOB: ______________ Date of Exam:___________

Physician’s/Practitioner’s Name:____________________________________________________________________

Physician’s/Practitioner’s Phone:_____________________Physician’s/Practitioner’s Fax:______________________

Please complete, sign and date all three pages and attach a copy of the most current immunizations records.
Camper’s physical exam must be within 12 months of the end date of their selected camping session.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>STATUS</th>
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<tbody>
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</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>
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<tr>
<th>HT:</th>
<th>WT:</th>
<th>HR:</th>
<th>BP:</th>
<th>RR:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>WITHIN NORMAL LIMITS</th>
<th>ABNORMAL</th>
<th>REASON</th>
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<tbody>
<tr>
<td>HEENT</td>
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<td>NECK</td>
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<td>LUNGS</td>
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<td>HEART</td>
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<td>ABDOMEN</td>
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<td>GENITALIA</td>
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<tr>
<td>SPINE</td>
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<tr>
<td>EXTREMITIES</td>
<td></td>
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<td></td>
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<td>NEURO</td>
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<tr>
<td>SKIN</td>
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</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>
<th>PLEASE LIST ANY SPECIAL WAYS TO GIVE THE MEDICATION</th>
</tr>
</thead>
<tbody>
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</table>

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: _____________________________
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: ________________________________

Place in the classroom:  

- Leader  
- Independent  
- Friendly  
- Follower  
- Quiet  

Relationship to peers:  

- Outgoing  
- Several friends  
- One friend  
- Shy  

Relationship to teacher:  

- Responsive  
- Cooperative  
- Dependent  
- Attention seeking  
- Respectful of authority  
- One to one attention needed  

Following directions:  

- Cooperative  
- Testing  
- Needs adaptation  
- Resentful to authority  

PC ages 13-16: demonstrate Leadership Skills:  

- Role model  
- Teamplayer  
- Self-motivated  
- Takes initiative  
- Accepts directions  
- Willingly performs tasks  

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  
- Non-compliant  
- Eats inedibles  
- Inappropriate language  
- Inappropriate sexual behaviors  
- Destroys property  
- Self-injurious behaviors  

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

Does this student have a  

- Behavior Intervention Plan  
- IEP  
- 504 Plan  

Please forward copy of all applicable plans with reference letter  

Please explain any behaviors that were checked off:  

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

In the past year has the child been 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 2022-2023 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>$26,973</td>
<td>$2,248</td>
<td>$1,124</td>
<td>$1,038</td>
<td>$519</td>
</tr>
<tr>
<td>2</td>
<td>$36,482</td>
<td>$3,041</td>
<td>$1,521</td>
<td>$1,404</td>
<td>$702</td>
</tr>
<tr>
<td>3</td>
<td>$45,991</td>
<td>$3,833</td>
<td>$1,917</td>
<td>$1,769</td>
<td>$885</td>
</tr>
<tr>
<td>4</td>
<td>$55,500</td>
<td>$4,625</td>
<td>$2,313</td>
<td>$2,135</td>
<td>$1,068</td>
</tr>
<tr>
<td>5</td>
<td>$65,009</td>
<td>$5,418</td>
<td>$2,709</td>
<td>$2,501</td>
<td>$1,251</td>
</tr>
<tr>
<td>6</td>
<td>$74,518</td>
<td>$6,210</td>
<td>$3,105</td>
<td>$2,867</td>
<td>$1,434</td>
</tr>
<tr>
<td>7</td>
<td>$84,027</td>
<td>$7,003</td>
<td>$3,502</td>
<td>$3,232</td>
<td>$1,616</td>
</tr>
<tr>
<td>8</td>
<td>$93,536</td>
<td>$7,795</td>
<td>$3,898</td>
<td>$3,598</td>
<td>$1,799</td>
</tr>
<tr>
<td>For each additional family member, add</td>
<td>$9,509</td>
<td>$793</td>
<td>$397</td>
<td>$366</td>
<td>$183</td>
</tr>
</tbody>
</table>

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

### Camp and/or closed enrolled site information

<table>
<thead>
<tr>
<th>Session Name &amp; Date</th>
<th>Meals Available</th>
<th>Service Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: 06/26/2023 - 06/30/2023</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: 07/03/2023 - 07/07/2023</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: 07/10/2023 - 07/14/2023</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: 07/17/2023 - 07/21/2023</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: 07/24/2023 - 07/28/2023</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: 07/31/2023 - 08/04/2023</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: 08/07/2023 - 08/11/2023</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: 08/14/2023 - 08/18/2023</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)
INCOME ELIGIBILITY FORM
SUMMER FOOD SERVICE PROGRAM (For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to: Cradle Beach Camp, 8038 Old Lakeshore Rd., Angola, NY 14006. If you need help, call Cradle Beach Camp Admissions Assistance at (716) 549-6307 ext. 205.

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.

In Box 1, list the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
In Box 2, list the amount each person got last month from welfare, child support, alimony.
In Box 3, list Social Security, pensions, and retirement.
In Box 4, list ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
.Column C–Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn’t have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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, 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.

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

## Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **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

<table>
<thead>
<tr>
<th>Example: $100/monthly</th>
<th>$100/twice a month</th>
<th>$100/every other week</th>
<th>$100/weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>$<strong><strong>/</strong></strong></td>
<td>$<strong><strong>/</strong></strong></td>
<td>$<strong><strong>/</strong></strong></td>
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<td>2.</td>
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<tr>
<td>11.</td>
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<td>$<strong><strong>/</strong></strong></td>
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<tr>
<td>12.</td>
<td>$<strong><strong>/</strong></strong></td>
<td>$<strong><strong>/</strong></strong></td>
<td>$<strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

### 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:  
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

Mark one or more racial identities:
- [ ] Asian
- [ ] American Indian or Alaska Native
- [ ] White
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Black or African American

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

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

Total Income: __________  Per: [ ] Week, [ ] Every 2 Weeks, [ ] Twice A Month, [ ] Month, [ ] Year

Household size: __________

Categorical Eligibility:  
- [ ] Date Withdrawn: ________  Eligibility: Free___  Reduced___  Denied___

Reason: ________________________________________________________________________________________

Determining Official’s Signature: ___________________________  Date: ______________

Confirming Official’s Signature: ___________________________  Date: ______________

Follow-up Official’s Signature: ___________________________  Date: ______________
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 6)
- The Medical Disclaimer (Camp Application Packet - Page 6)
- The Permission Page (Camp Application Packet – Page 11)
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:
Erie County Department of Social Services
95 Franklin Street
Buffalo, New York 14202

Persons/organizations receiving the information:
Summer Camps- for the purpose of determination of eligibility for ECDSS Summer Camp Program (to pay camper’s fees up to allowable amount).

CAMP NAME:    CRADLE BEACH, 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)

g _______________________________  (Caseworker)

Caseworker Telephone Number: ________________________________

B-5706 (5/16)
CREDIT CARD FORM FOR CAMPER’S FEES

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

Camper’s Name: _________________________________________________________

Card Holder’s Name: ______________________________________________________________________________________

Card Holder’s Address: ______________________________________________________________________________________

Card Holder’s City/ State/ Zip: ______________________________________________________________________________________

Card Holder’s Telephone: (________) ____________________________________________________________________________

Credit Card: ☐ VISA ☐ MASTER CARD ☐ AMERICAN EXPRESS ☐ DISCOVER

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

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

Exp. Date: ___________________________

Amount to be charged: $ ______________

Card Holder Signature: __________________________________________

Please Check All that apply:

☐ 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 USE ONLY

Received By: __________________________________________ Date: _____________________________

☐ Credit Card Approved

☐ Credit Card Declined Date Declined: ______________

☐ Notified Parents Date Parents Notified: ______________