

Medical Recommendation for Camp Employee

*Return this completed form
to:*

Camp O-AT-KA
P.O. Box 239
Sebago, ME 04029
(207) 787-3401
(207) 787-3930 fax

To Physicians and Their Staff:

This person is an employee at **Camp O-AT-KA**. The job includes physical activity such as **[insert most rigorous job duty]** and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's work supervisor use the information provided on this form to guide their interface with the employee. The employee can provide their job's description and list of essential functions to you. If you question the person's suitability for their job, please talk with them about your concerns and develop a plan to address that concern. You can also speak to one of our camp professionals by calling (207) 787-3401. Thank you!

<p>These medications are stocked in our camp's Health Center and will be used to manage illness and/or injury of this employee.</p> <p>CROSS OUT those that are contraindicated for this person.</p> <p>[insert Camp's list of medications such as those that follow]</p> <p>Acetaminophen Aloe Bismuth Chew Tabs Calamine Lotion Chlorpheniramine maleate Diphenhydramine Epinephrine Guiafenesin DM Hydrocortisone Cream Ibuprofen Kaopectate Cough Drops Ivy Dry Nix Tolnaftate Topical Antibiotic Cream Pseudoephedrine Silver Sulfadiazine</p>	<p>Name of Staff Member:</p> <p>_____</p>	<p>Date of Birth: _____</p>
	<p>1. List the chronic health problems of this employee: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Allergies <input type="checkbox"/> Other: _____</p>	
	<p>2. List the prescription medication(s) this person will take while at camp; provide a medical order for administration.</p> <p><input type="checkbox"/> None needed while at camp.</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	
	<p>3. List the allergies (food, medication, etc) of this person <input type="checkbox"/> No known allergies</p> <p>a. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis</p> <p>b. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis</p> <p>c. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis</p> <p><i>Note: Our expectation is that the employee will have an EpiPen and know how to use it if anaphylaxis is part of the individual's health profile.</i></p>	
<p>4. Describe other treatments needed by this person to do their job <input type="checkbox"/> None needed</p> <p>_____</p> <p>_____</p> <p>_____</p>		

5. Describe any significant physical findings regarding this person and/or describe any limitations that may impact the employee's job performance.

No significant findings.

6. We may have neglected to ask about something you feel is needed to adequately address this person's health needs. If so, please add your comments below. No additional comments needed.

Your
Signature: _____

Date: _____

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as an employee at our camp except as noted in your comments.