

MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:

CAMP BEAR TRACK
PO Box 125
Drasco AR 72530

Phone: 501-825-8222
FAX: 501-825-8255

To Physicians and Their Staff:

CURRENT SHOT RECORDS MUST ACCOMPANY THIS FORM!

This person is an employee at Camp Bear Track in Drasco, AR. The job includes physical activity such as a **sports instructor** 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 **501-825-8222** Thank you!

These medications are stocked in our camp's Health Center and will be used to manage illness and/or injury of this employee.

CROSS OUT those that are contraindicated for this person.

- Acetaminophen
- Aloe
- Calamine Lotion
- Chlorpheniramine maleate
- Diphenhydramine
- Epinephrine
- Guiafenesisin DM
- Hydrocortisone Cream
- Ibuprofen
- Kaopectate
- Cough Drops
- Ivy Dry
- Nix
- Tolnaftate
- Topical Antibiotic Cream
- Pseudoephedrine
- Silver Sulfadiazine

Name of Staff Member: _____ Date of Birth: _____

1. List the chronic health problems of this employee: None

- Asthma Diabetes
- Allergies Other: _____

2. List the prescription medication(s) this person will take while at camp; provide a medical order for administration.

- None needed while at camp.
- a. _____
- b. _____
- c. _____

3. List the allergies (food, medication, etc) of this person No known allergies

- a. _____ Intolerance Anaphylaxis
- b. _____ Intolerance Anaphylaxis
- c. _____ Intolerance Anaphylaxis

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.

4. Describe other treatments needed by this person to do their job None needed

Diet, Nutrition: ___ This person eats a regular diet. ___ This person eats a regular vegetarian diet.
 ___ This person has special food needs. Please describe: _____

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.

