MEDICAL RECOMMENDATION for CAMP EMPLOYEE

These and/or other 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
Bismuth Chew Tab
Calamine Lotion
Chlorpheniramine maleate
Diphenhydramine
Epinephrine
Guaifenesin DM
Hydrocortisone Cream
Ibuprofen
Kaopectate
Cough Drops
Ivy Dry
Nix
Tolnaftate
Tropical Antibiotic Cream
Pseudoephedrine

Dr. Authorization

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.

Physician Name: _____

Physician Signature: _____

Date: _____

Address:
_____

Phone number: _____

Date of last physical exam: _____

******PLEASE INCLUDE UPDATED VACCINE RECORD ******

Physician Stamp:

To Physicians and their Staff:
This person is an employee at JCC Camp by the Sea. The job includes physical activity and requires the individual to be outside in a variety of weather conditions. Our healthcare staff use the information 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 him or her about your concerns and develop a plan to address that concern.

Name of Employee: _____ Date of Birth _____

1. Does this person have a chronic health problem(s) that may prevent them from fulfilling the essential functions of their job? . . . . . ☐ No
   ☐ Asthma ☐ Allergies ☐Diabetes
   ☐ Other _____

2. To what is this person allergic? . . . . . ☐ No Allergies
   a. _____ ☐ Causes anaphylaxis
   b. _____ ☐ Causes anaphylaxis
   c. _____ ☐ Causes anaphylaxis
   Note: Our expectation is that the employee will have an EpiPen® and know how to use it if anaphylaxis is a concern.

3. Does this individual take any medication(s) that the use of (or non-use) could impair his/her ability to perform the essential functions of his/her job? If so, please list below: . . . . ☐ No medication that impacts job function.
   a._____
   b. _____

4. Describe the treatment(s) needed by this person to maintain their ability to complete the essential functions of their job.
   ☐ None needed.
   ☐ Treatment as follows: _____
   _____
   _____

5. Describe any significant findings about this person and/or describe any limitations that may impact the employee's job performance.
   ☐ No significant findings.
   ☐ Findings as follows: _____
   _____
   _____

6. What else should the employer know about this employee's health insofar as its impact upon job performance?
   ☐ No other information needed.
   ☐ Information as follows: