MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:

Camp Kupugani / White Eagle
6903 W. White Eagle Road
Leaf River IL 61047
815-713-4110

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
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

To Physicians and Their Staff:

This person is an employee at **Camp Kupugani / White Eagle**. The job includes physical activity such as **rock climbing** 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 **815-713-4110**. Thank you!

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

_____

_____

_____

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.

_____

_____

_____

Doctor's Signature: _____ Date: _____

PRINTED NAME (OR STAMP) _____

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.