

MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:
Blue Mountain Ranch Summer Camp
 P. O. Box 146
 Florissant, CO 80816
 (719) 748-3279 Office
 (719) 748-3472 FAX

To Physicians and their Staff:

This person is an employee at **Blue Mountain Ranch Summer Camp** located in **Florissant, Colorado**. The job includes physical activity such as lifting heavy objects and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's supervisor 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. You may also speak to one of our camp professionals by calling **(719) 748-3279**. 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
 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

Name of _____ Date of _____
 Employee: _____ 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: _____

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.

Your
 Signature: _____
 Date: _____

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: _____