

**MEDICAL RECOMMENDATION for CAMP EMPLOYEE**

*Return this completed form to:*

**Camp Juliette Low**  
 P. O. Box 5113  
 Marietta, GA 30060  
 770-428-1062

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.

[Insert list of medications stocked in the Health Center such as those that follow]

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

**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:* \_\_\_\_\_

*To Physicians and their Staff:*

This person is an employee at [insert camp name & location]. 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 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 [insert phone number]. Thank you!

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
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 it impact upon job performance?  
 No other information needed.  
 Information as follows: \_\_\_\_\_

