

MEDICAL RECOMMENDATION for CAMP VOLUNTEER OR STAFF

Return this completed form to:

Camp Twin Lakes, Will-A-Way
Attn: Kristen Hill
210 S. Broad Street, Unit 5
Winder, GA 30680

770-867-6123 Ext 229

To Physicians and Their Staff:

This person is applying to volunteer at Camp. The job includes physical activity such as **walking up to a mile daily** and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the supervisor use the information provided on this form to guide their interface with the volunteer. The volunteer 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 **770.867.6123**. 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
- Ibuprofen
- Naproxen
- Diphenhydramine
- Loratadine
- Stool softener
- Anti-diarrheal
- Pepto-bismol
- Anti-nausea
- Antacids
- Simethicone
- Lice shampoo
- Cough drops
- Eye wash/drops
- Saline nose spray
- Swimmer's ear
- Antifungal cream
- Antibiotic ointment
- Hydrocortisone cream
- Burn gel/spray
- Aloe
- Calamine lotion
- Glucose tabs

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 Unknown 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.

Healthcare Provider's
 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.