

# MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:

Belvoir Terrace  
101 W. 79<sup>th</sup> St., #15B  
New York, NY 10024  
212-580-3398

Or after May 10<sup>th</sup> to:

Belvoir Terrace  
80 Cliffwood Street  
Lenox, MA 01240  
413-637-0555

**To Physicians and Their Staff:**

This person is an employee at **Belvoir Terrace** in Lenox, Massachusetts. The job includes physical activity 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 212-580-3398. 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 Tabs
- Calamine Lotion
- Chlorpheniramine maleate
- Diphenhydramine
- Epinephrine
- Guafenesin DM
- Hydrocortisone Cream
- Ibuprofen
- Kaopectate
- Cough Drops
- Ivy Dry
- Nix
- Tolnaftate
- Topical Antibiotic Cream
- Pseudoephedrine
- Silver Sulfadiazine

Name of Staff Member: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Physical exam done today:**  Yes  No

Weight: \_\_\_\_\_ lbs

If "No," date of last physical: \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

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. \_\_\_\_\_

3. List the allergies (food, medication, etc ) of this person \_\_\_\_\_  No known allergies

a. \_\_\_\_\_  Intolerance  Anaphylaxis

b. \_\_\_\_\_  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.

\_\_\_\_\_  
\_\_\_\_\_

Name of licensed provider (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

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.