

## 2010 MEDICAL RECOMMENDATION for CAMP EMPLOYEE / VOLUNTEER

Mailed completed form to:  
**Camp Ho Mita Koda**  
**3601 S. Green Rd.,**  
**Suite 100**  
**Cleveland, OH 44122**

**Deadline: May 14, 2010**  
 (Staff hired after May 14 must  
 return this form with their  
 employment contract)

These medications are stocked in our camp's dispensary and will be used to manage illness and/or injury of this employee.

**CROSS OUT** those that are contraindicated for this person.

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin),
- Pseudoephedrine (Sudafed)
- Guaifenesin,
- Dextromethorphan,
- Diphenhydramine (Benadryl)
- Generic cough drops
- Calamine lotion
- Laxatives for constipation (kaopecate)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Aloe
- Maalox for mild indigestion

-Loperamide for diarrhea

-Bromphenimine and pseudoephedrine (Dimetapp Elixir) for cold and allergy symptoms.

*Licensed Physician:*

This person is an employee at **Camp Ho Mita Koda in Newbury, OH**. The job includes physical activity such as walking, running, bending, and lifting. Staff will provide supervision of campers and work a variety of hours, including overnights. This job requires the individual to be outside in a variety of weather conditions. Our dispensary staff and the employee's work supervisor use the information provided on this form to guide their interactions 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 our Camp Manager by calling **216-591-0800** 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..

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.

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

Physician  
 Signature: \_\_\_\_\_  
 Address \_\_\_\_\_

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.