

STAFF HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM

Please Print All Information

<p>Please return Completed Form by May 1st to:</p> <p>Camp Agawam 54 Agawam Road Raymond, ME 04071</p> <p>Questions? Please call: September 1st to May 31st (207) 892-1200 June 1st to August 31st (207) 627-4780</p>	<p><i>To Physicians and Their Staff:</i></p> <p>This person is an employee at Camp Agawam in Raymond, ME. The job includes physical activity such as sport and hiking, 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 us on 207-627-4780. Thank you!</p>
<p>The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an <u>as needed</u> basis to manage illness and/or injury.</p> <p><u>Medical personnel:</u> CROSS OUT those items that are contraindicated for this person:</p> <p>Acetaminophen (Tylenol) Aloe Antibiotic cream, topical Antihistamine/allergy medicine Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) Calamine lotion Chlorpheniramine maleate Dextromethorphan cough syrup (Robitussin DM) Diphenhydramine antihistamine/allergy medicine (Benadryl) Generic cough drops Guaifenesin cough syrup (Robitussin) Hydrocortisone Cream Ibuprofen (Advil, Motrin) Ivy Dry Laxatives for constipation (Ex-Lax) Lice shampoo or cream (Nix or Elimite) Phenylephrine decongestant (Sudafed PE) Pseudoephedrine decongestant (Sudafed) Silver Sulfadiazine Sore throat spray Tolnaftate</p>	<p>Staff First name: _____ Middle name: _____ Last name: _____</p> <p>Dates will attend camp: ____/____/____ to ____/____/____ Month Day Year Month Day Year</p> <p>Applicant Date of Birth: ____/____/____ <input type="checkbox"/> M or <input type="checkbox"/> F Month Day Year</p> <p>Physical exam done today: <input type="checkbox"/> Yes or <input type="checkbox"/> No (If no, date of last physical: ____/____/____) Month Day Year ACA accreditation standards specify physical exam within last 24 months.</p> <p>Chronic Health Problems: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Other (<i>list</i>):</p> <p>Allergies: <input type="checkbox"/> No known allergies List the allergies (food, medication, etc) of this person: a. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis b. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis c. _____ <input type="checkbox"/> Intolerance <input type="checkbox"/> Anaphylaxis</p> <p>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.</p> <p>Other Treatment: Describe other treatments needed by this person to do their job: <input type="checkbox"/> None</p> <p>Medication: <input type="checkbox"/> No daily medications. <input type="checkbox"/> Will take the following prescribed medication(s) while at camp (Please provide a medical order for administration (name, dose, frequency):</p> <p>Job Performance: Describe any significant physical findings regarding this person and/or describe any limitations that may impact the employee's job performance: <input type="checkbox"/> No significant findings</p>
<p>Other: 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 (describe – attach additional information if needed): <input type="checkbox"/> No additional comments needed</p>	
<p>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.</p>	
<p>Name of licensed provider (please print): _____ Signature: _____ Title: _____ Office Address: _____ City: _____ State: _____ Zip: _____ Telephone: (____) _____ (____) _____ Date: ____/____/____ Month Day Year</p>	