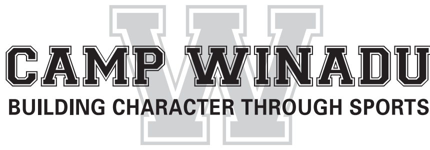

PLEASE RETURN TO:

WINTER (September 1 - May 31)
3 New King St., White Plains, NY 10604
p: 914-437-7200 f: 914-422-3635

SUMMER (June 1 - August 31)
700 Churchill Street, Pittsfield, MA 01201
p: 413-447-8900 f: 413-447-8905

STAFF MEDICAL FORM

TO BE COMPLETED BY LICENSED PHYSICIAN

To Physicians and Their Staff: This person is an employee at **Camp Winadu in Pittsfield, 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 **(914) 437-7200.** 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; provide a medical order for administration. ☐ 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. ______________________________

____

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

Please check those that are contraindicated for this person.

☐ Tylenol ☐ Motrin ☐ Pepto Bismal ☐ Tums ☐ Immodium AD ☐ Calamine Lotion ☐ Rhuli Gel ☐ Tinactin

☐ Solarcaine ☐ Benadryl ☐ Sudafed ☐ Dramamine ☐ Lactaid

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.

Name of Licensed Physician: ____________________ Signature: ____________________ Title:_____

Office Address: ____________________ City: ____________________ State:_______ Zip:_________

Telephone Number: ______________________________ Date: ____________________