MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:
Deer Crossing Camp | Bay Area Office
690 Emerald Hill Road
Redwood City, CA 94061 USA
PH/Fax 650-369-4382
mail@deercrossingcamp.com

These OTC medications may be stocked in our camp's Health Room and may be used to manage illness and/or injury of this employee.
CROSS OUT those that are contraindicated for this person.

Acetaminophen
Aloe
Antidiarrheal
Bismuth subsalicylate
Calamine lotion
Chlorpheniramine maleate
Cough drops
Diphenhydramine
Guaifenesin DM
Ibuprofen
Loratadine
Pediculosis treatment
Pseudoephedrine hydrochloride
Tolnaftate
Tropical antibiotic cream

Authorization

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 high-altitude, wilderness camp, except as noted in your comments.

Your Signature: _____

Name: _____

Date: _____

To Physicians and their Staff:
This person is an employee at Deer Crossing Camp, a high-altitude, wilderness camp in California. The job includes physical activity such as teaching advanced windsurfing or rock-climbing, carrying 50-lb. packs over rough terrain for three days, and requires the individual to be outside in a variety of weather conditions. Our Camp Director uses the information on this form to guide his 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 the job, please talk with him or her about your concerns and develop a plan to address that concern. You may also speak to the Camp Director or Office Managers (the camp's owners) by calling 650-369-4382. Thank you!

Name of Employee: _____ Date of Birth: _____

1. Does this person have a chronic health problem(s) that may prevent them from fulfilling the essential functions of their job? . . . . . ☐ No
   ☐ Asthma ☐ Allergies ☐Diabetes
   ☐ Other _____

2. To what is this person allergic? . . . . . ☐ No Allergies
   a. _____ ☐ Causes anaphylaxis
   b. _____ ☐ Causes anaphylaxis
   c. _____ ☐ Causes anaphylaxis
   Note: Our expectation is that the employee will have EpiPens® and know how to use them if anaphylaxis is a concern.

3. Does this individual take any medication(s) that the use of (or non-use) could impair his/her ability to perform the essential functions of his/her job? If so, please list below: . . . . ☐ No medication that impacts job function.
   a._____
   b. _____

4. Describe the treatment(s) needed by this person to maintain their ability to complete the essential functions of their job.
   ☐ None needed.
   ☐ Treatment as follows: _____
   _____
   _____

5. Describe any significant findings about this person and/or describe any limitations that may impact the employee's job performance.
   ☐ No significant findings.
   ☐ Findings as follows: _____
   _____
   _____

6. What else should the employer know about this employee's health insofar as its impact upon job performance?
   ☐ No other information needed.
   ☐ Information as follows: _____
   _____