MEDICAL Clearance for CAMP EMPLOYEE

Return this completed form to:
YMCA of Greater Boston Overnight Camps
PO Box 10
Mirror Lake, NH
03853

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.

[Insert list of medications stocked in the Health Center such as those that follow]
Acetaminophen
Aloe
Bismuth Chew Tab
Calamine Lotion
Chlorpheniramine maleate
Diphenhydramine
Epinephrine
Guaifenesin DM
Hydrocortisone Cream
Ibuprofen
Kaopectate
Cough Drops
Ivy Dry
Nix
Tolnaftate
Tropical Antibiotic Cream
Pseudoephedrine

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 camp, except as noted in your comments.

Your Signature: _____

Date: _____

To Physicians and their Staff:
This person is an employee at [insert camp name & location]. The job includes physical activity such as [caring for children, driving vehicles and lifting up to 50 lbs] and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's supervisor use the information 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 him or her about your concerns and develop a plan to address that concern. You may also speak to one of our camp professionals by calling [insert phone number]. 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 an EpiPen® and know how to use it 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: