



**PLEASE RETURN THIS FORM TO CAMP MAH-KEE-NAC AS SOON AS POSSIBLE:**

**WINTER** (Until May 30th): 3 New King Street, White Plains, NY 10604 • p: 800-753-9118 • f: 914-997-6063

**SUMMER** (After May 30th): 6 Hawthorne Road, Lenox, MA 01240 • p: 800-753-9118 • f: 413-637-8245

# STAFF MEDICAL FORM 2010

To Physicians and Their Staff: This person is an employee at Camp Mah-Kee-Nac, Lenox, MA. The job includes physical activity that is vigorous and requires the individual to be outside in a variety of summer 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 **(800) 753-9118 / (914) 997-6043**. 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. I examined this individual on \_\_\_\_\_. (Exam is required within 24 months of camp attendance)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date Completed \_\_\_\_\_

7. 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 Bismol     Tums     Imodium AD     Mylanta     Calamine Lotion / Anti-itch Gel
- Cortaid     Tinactin     Solarcaine     Benadryl     Sudafed     Robitussin / Robitussin DB     Dramamine

*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: \_\_\_\_\_