MEDICAL EVALUATION
FOR SUMMER CAMP EMPLOYEE

NAME OF STAFF MEMER .....

DATE OF BIRTH ...../...../.....

TO GPs AND THEIR STAFF

This person is an employee at Country House Camp. The job includes looking after children aged 8-12 on a daily basis as well as physical activity such as practicing sports, running games and occasionally lifting weights. In addition, it requires the individual to be outside in a variety of weather conditions.
If you question the person's suitability for their job, please ask them to provide a job description to you, which will contain a detailed list of essential functions.

Thank you!

Country House Camp team

1. Does this person have any chronic health problems? If so, please list them:

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2. Will this person have to take any prescription medication(s) while at camp? If so, please provide a medical order for administration.

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To your knowledge, does this person have any allergies (food, medication, etc.)? If so, please circle the type of reaction for each allergy.

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 their health profile.

4. If necessary, describe other treatments needed by this person to do their job.

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5. Are there any other significant physical / emotional findings regarding this person and/or any limitations that may impact their job performance? If so, please describe them.

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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.

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By signing this form, you are telling us that after examining this person and assessing their medical history, you found no physical or emotional reason which would make it medically inadvisable for this person to be a summer camp employee, which includes looking after children as well as physically strenuous activities, except as noted in your comments.

DOCTOR'S SIGNATURE ..... DATE .....

PRINTED NAME .....

NAME OF THE PRACTICE ..... PHONE .....

DOCTOR'S STAMP (REQUIRED):