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ACA Accredited

Form 2: Employee Health Recommendations

(To be completed by Licensed Medical Professional)

Employee Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Date of Birth: _____ (MM/DD/YY)

NYS Dept of Health requires a complete physical exam within 12months of employment

Date of Last Physical Exam: _____ (MM/DD/YY)

Weight: _____ lbs

Height ____ ft ____ in

HR: _____ bpm

BP: _____/_____

Allergies: (Please Specify)

☐ Food:
☐ Medications:
☐ Environment:
☐ Other:

Describe Previous Reactions. Risk of Anaphylaxis? (Submit Emergency Action Plan, if applicable)

Does this employee require an EpiPen? ☐ Yes ☐ No

If Yes
☐ EpiPen (0.3mg/0.3ml) IM
☐ EpiPen Jr (0.15mg/0.15ml) IM

Diet/Nutrition:

☐ No Diet Restrictions ☐ Vegan ☐ Lactose Intolerant
☐ Vegetarian ☐ Gluten Free ☐ Other (Specify):

The employee is undergoing treatment at this time for the following conditions: (describe below)

☐ None

Other treatments/therapies to be continued at camp: (describe below)

☐ None Needed

Employee Health Form 2
(To be completed by Licensed Medical Professional)

Employee Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Restrictions:
Do you feel that the employee will require limitations or restrictions to activity while at camp?
☐ No ☐Yes
If you answered yes to this question, what do you recommend? (describe below or include attachment)

Immunization History: Attach copy of immunization forms from Health Care provider or State/Local government.

Immunization	Dose 1 Month/Yr	Dose 2 Month/Yr	Dose 3 Month/Yr	Dose 4 Month/Yr	Dose 5 Month/Yr	Most Recent Dose Month/Yr
Diptheria, tetanus, pertussis (DTaP)/(TdaP)						
Tetanus Booster (dT) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) Test Date: _____ **Result:** ☐ Negative ☐Positive ☐N/A

Employee Health Form 2
(To be completed by Licensed Medical Professional)

Employee Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Individualized Standing Orders (Non-Prescription Medications):

The following non-prescription medications are available in the Camp Health Center. New York State Law requires approval by a Licensed Health Care Professional (MD, DO, NP or PA) for these medications to be dispensed to the employee when indicated.

Drug Name	Route	Dosage & Schedule	Schedule & Indications	Healthcare Provider Order & Initial		Comments
Acetaminophen (Tylenol)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Ibuprofen (Motrin/Advil)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Decongestant/cough suppressant (Dayquil/Robitussion)	PO	Per label instructions	Cough	☐ Yes	☐ No	
Throat lozenges and/or Chloroseptic spray	PO	Per label instructions	Sore throat	☐ Yes	☐ No	
Laxatives (Milk of Magnesia/Miralax)	PO	Per label instructions	Constipation	☐ Yes	☐ No	
Bismuth (Children's Pepto Bismol)	PO	Per label instructions	Indigestion, Nausea, Emesis	☐ Yes	☐ No	
Antacid: (Maalox/Tums/Mylanta)	PO	Per label instructions	Abdominal Upset	☐ Yes	☐ No	
Ear drying aid (Swimmers ear)	topical	Per label instructions	Suspicion of Swimmer's ear	☐ Yes	☐ No	
Antihistamine (Diphenhydramine/ Cetiriine/Fexofenadine/ Loratidine)	PO	Per label instructions	Allergic reaction (itching, rash, hives) Seasonal Allergy symptoms	☐ Yes	☐ No	
1% Hydrocortisone	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Diphenhydramine cream/ointment	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Calamine lotion or generic	topical	Per label instructions	Insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Over-the-Counter Pediculocide	topical	Per label instructions	Head lice	☐ Yes	☐ No	
Analgesic balm (Mineral Ice/Icy-Hot)	topical	Per label instructions	Muscle aches and backaches	☐ Yes	☐ No	
Hydrogen Peroxide	topical	Per label instructions	Wound cleansing	☐ Yes	☐ No	
0.9 % Sodium chloride	topical	Per label instructions	Wound cleansing, Eye irritation, soak	☐ Yes	☐ No	
Povidone Iodine swab	topical	Pre-packaged	Wound disinfectant	☐ Yes	☐ No	
Antibacterial Ointment (Bacitracin/Triple Antibiotic)	topical	Per label instructions	Abrasions, cuts, scratches and infections	☐ Yes	☐ No	

Employee Health Form 2 (To be completed by Licensed Medical Professional)	Employee Name: ________________________________ (Last Name) (First Name) (Middle Initial)	Date of Birth: __________ (MM/DD/YY)

Employee Medications to be taken at camp: (to be filled by Health Care Provider)
Please list all medications the employee will require to take at camp. This includes over-the-counter or non-prescription medications taken routinely or as needed (PRN). Parents of employees under the age of 18 must send medication in un-opened original packaging. Medication in unlabeled bottles or pill boxes will not be accepted . All medication must be submitted to the Camp Health Care center, and cannot be kept with the employee. Employees 18 years of age and older, must keep all medications secured in the Den.

Medication: ☐ This person will not take any daily medications while attending camp.
☐ This person will take the following daily medication(s) while at camp.

Prescription/Non Prescription Medication	Route	Dosage	Schedule	Indications
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	

I have reviewed the employee's health history and have discussed the camp program with the employee and/or their parent/guardian. It is my opinion that the employee is physically and emotionally fit to participate in an active camp program (except as noted above on page 2 above).

Name of Licensed provider (print)________________________________ Signature___________________________

Office Address ____

Telephone ____ Date____