Health-Care Provider Recommendations FORM 2

<u>To Adult Staff:</u> Complete this section and give this form (FORM 2) and a copy of your completed Medical History Form (or medical history from physical exam) to your health-care provider for review.

Name: ____ Gender ______________

D.O.B____/____/____ Age at Camp_____ phone: (______)________________, (___________)_____________

Address:____

<u>Adult Staff:</u> stop here. Rest of form to be completed by medical personnel.

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<u>To Medical Personnel:</u> Please review participant medical history and complete all remaining sections of this form. Attach additional information as needed.

This person is an adult seasonal staff or volunteer at Mountain Friends Camp. The job includes physical activity such as hiking and active games and requires the individual to be outside in a variety of weather conditions, above 7,000 ft altitude. Our healthcare staff and the camp director use the information on this form to guide their interface with the staff member. They can provide a full positon description to you. If you question the person's suitability for their role at camp, please talk with them about your concerns and develop a plan to address that concern. You may also speak to the camp director by calling 435-554-1332. Thank you!

Physical exam done today: ☐ Yes ☐ No (if "No", date of last physical **:________________________)**

Allergies: ☐ Yes ☐ No Known Allergies

To foods (list):

To medications: (list):

To the environment (insect stings, hay fever, etc.– list):

Other allergies: (list):

Describe previous reactions:

Known **Communicable Diseases**: ☐ Yes ☐ No (If "Yes" describe below):

Are there any **limitations or restrictions** that might impact their job performance while at camp?

☐ Yes ☐ No (if "Yes", what do you recommend)

Participant is undergoing **treatment** or taking **medication** that the use of (or non-use) could impair their ability to perform the essential functions of the job: ☐ Yes ☐ No (If "Yes" describe below):

"I have reviewed relevant medical history and have discussed the camp program with this person. It is my opinion that this person is physically fit to participate in all activities at Mountain Friends Camp (except as noted here.)

Name of licensed physician or PA (please print): ____

Signature: ____Title: ______________________

Office Address____

Telephone: (________)_____________________ Date:_______________________

Participant Information

Name____ D.O.B___/___/__

Medical Personnel

If you answered "Yes" to any of the above questions, please describe in detail, use additional pages and attachments if necessary:

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