Sickle Cell Foundation of Georgia, Inc.

MEDICAL RECOMMENDATION for CAMP VOLUNTEER OR STAFF

Return this completed form to:

Sickle Cell Foundation of Georgia

Camp New Hope
2391 Benjamin E. Mays Dr.
Atlanta, Georgia 30311

404-755-1641 Ext 215

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.

Acetaminophen
Ibuprofen
Naproxen
Diphenhydramine
Loratadine
Stool softener
Anti-diarrheal
Pepto-bismol
Anti-nausea
Antacids
Simethicone
Lice shampoo
Cough drops
Eye wash/drops
Saline nose spray
Swimmer's ear
Antifungal cream
Antibiotic ointment
Hydrocortisone cream
Burn gel/spray
Aloe
Calamine lotion
Glucose tabs

To Physicians and Their Staff:

This person is applying to volunteer at Camp. The job includes physical activity such as **walking up to a mile daily** and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the supervisor use the information provided on this form to guide their interface with the volunteer. The volunteer 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 **404.755.1641**. Thank you!

Name of Staff Member: _____ Date of Birth: _____

1. List the chronic health problems of this employee: . . . . . ☐ None

☐ Asthma ☐ Diabetes ☐ Allergies

☐ Sickle Cell Disease ☐ 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. Has this person been hospitalized in the past 6 months……..☐ Yes ☐ No

4a. If yes, please explain _____

5. Describe other treatments needed by this person to do their job . . . . . ☐ None needed

_____

_____

_____

6. Describe any significant physical findings regarding this person and/or describe any limitations that may impact the employee's job performance.

☐ No significant findings.

_____

_____

_____

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.

_____

_____

_____

Healthcare Provider's Signature: _____ Date: _____

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.