MEDICAL RECOMMENDATION for CAMP VOLUNTEER

Return this completed form to:

Camp Hope
15 Ridgeway Avenue
Blairstown, NJ 07825
(908) 459-4435

These medications are stocked in our camp's Health Center and will be used to manage illness and/or injury of this volunteer.
CROSS OUT those that are contraindicated for this person.

- Acetaminophen (Tylenol)
- Phenylephrine decongestant (Sudafed PE)
- Antihistamine/allergy medicine
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Sore throat spray
- Lice shampoo or cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Ibuprofen (Advil, Motrin)
- Pseudoephedrine decongestant (Sudafed)
- Guaifenesin cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Generic cough drops
- Antibiotic cream
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
- Aloe

Authorization

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as a volunteer at our camp, except as noted in your comments.

Your Signature: _____

Date: _____

To Physicians and their Staff:
This person is a volunteer at Hope Conference & Renewal Center, Inc. (Camp Hope) in Blairstown, NJ. The position includes moderate physical activity and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the volunteer's supervisor use the information on this form to guide their interface with the volunteer. If you question the person's suitability as a volunteer, please talk with him or her about your concerns and develop a plan to address that concern. You may also speak to one of our camp professionals by calling (908) 459-4435. Thank you!

Name of Volunteer: _____ Date of Birth: _____

1. Does this person have a chronic health problem(s) that may prevent them from fulfilling the responsibilities of their position? . . . . . ☐ No
   ☐ Asthma ☐ Allergies ☐Diabetes
   ☐ Other _____

2. To what is this person allergic? . . . . . ☐ No Allergies
   a. _____ ☐ Causes anaphylaxis
   b. _____ ☐ Causes anaphylaxis
   c. _____ ☐ Causes anaphylaxis
   Note: Our expectation is that the volunteer will have an EpiPen® and know how to use it if anaphylaxis is a concern.

3. Does this individual take any medication(s) that the use of (or non-use) could impair their ability to fulfill the responsibilities of their position? If so, please list below: . . . . . ☐ No medication that impacts job function.
   a._____
   b. _____

4. Describe the treatment(s) needed by this person to maintain their ability to fulfill the responsibilities of their position.
   ☐ None needed.
   ☐ Treatment as follows: _____
   _____
   _____

5. Describe any significant findings about this person and/or describe any limitations that may impact their ability to fulfill the responsibilities of their position.
   ☐ No significant findings.
   ☐ Findings as follows: _____
   _____
   _____

6. What else should the camp director know about this volunteer's health as it concerns their ability to fulfill the responsibilities of their position?
   ☐ No other information needed.
   ☐ Information as follows: