

2025 DOCTOR'S STATEMENT FOR STAFF EMPLOYMENT



Staff Health Needs for Employment:

All Staff should be able to perform the essential functions of their position within this work environment:

Daily activity takes place at a starting altitude of 5200 feet for Day Camp locations and 9400 feet for Overnight Camp. Physical activities may be strenuous at times and may take staff up to 12,000 feet.

Temperatures may go above 95 degrees at Day Camp locations.

Overnight camp terrain is rustic and mountainous.

The group-based or community-living environment involves high social interaction each day.

Duties require extensive hours being the caretaker for youth that includes standing, swimming, athletic activity, ropes course participation, and lifting and carrying camper items and program supplies that may be over 30 pounds.

Staff are expected to self-manage and promote good mental, emotional, and physical health in a team environment.

A health care professional will be available at Overnight Camp when summer camp is in session. There is not a healthcare professional at Day Camp locations. For more urgent or extensive care, local clinics/hospitals are utilized in the Estes Park area and near Day Camp sites.

I confirm that within the preceding 12 months a health screening has been performed on:

STAFF MEMBER NAME: _____

and I found him/her to be in satisfactory physical and psychological condition to carry out his/her duties as a member of the staff at Camp Timberline, except as follows (please be specific and list any physical limitations or special care needed with necessary treatment):

Date Examined: _____ Height: _____ Weight: _____ Blood Pressure: _____

Has the staff member been diagnosed with a medical condition or disease of the blood, respiratory, metabolic, or other system, such as sickle cell disease or COPD/emphysema that would limit employment at camp with an altitude of 9,400 feet? YES / NO
If yes, please explain:

List any known drug, food, or environmental allergies and reactions that the staff member has:

Is the above named staff member current on his/her DTaP/Tdap and/or DT/Td immunization (received within the last 10 years)?
YES / NO Most Recent Date: _____

Signature of Physician/Nurse Practitioner/Physician's Assistant: _____

Date: _____

PHYSICIAN/NP/PA NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE NUMBER: _____