

Maryland State Child Care/Nursery School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)



Triggers (list)

Student's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Breathing is good	Medication	Dose	Route	Frequency
	<input type="checkbox"/> No cough or wheeze				
	<input type="checkbox"/> Can work, exercise, play				
	<input type="checkbox"/> Other: _____				
	<input type="checkbox"/> Peak flow greater than _____ (80% personal best)				
<input type="checkbox"/> Prior to exercise/sports/ physical education	(Rescue Medication)				
If using more than twice per week for exercise, notify the health care provider and parent/guardian.					

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Cough or cold symptoms	Medication	Dose	Route	Frequency
	<input type="checkbox"/> Wheezing				
	<input type="checkbox"/> Tight chest or shortness of breath				
	<input type="checkbox"/> Cough at night				
	<input type="checkbox"/> Other: _____				
<input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.				

RED ZONE: Emergency Medications — Take these medications and call 911

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE	<input type="checkbox"/> Medication is not helping within 15-20 mins	Medication	Dose	Route	Frequency
	<input type="checkbox"/> Breathing is hard and fast				
	<input type="checkbox"/> Nasal flaring or skin retracts between ribs				
	<input type="checkbox"/> Lips or fingernails blue				
	<input type="checkbox"/> Trouble walking or talking				
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Peak flow less than _____ (50% personal best)	Contact the parent/guardian after calling 911.				

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. Student may self-carry medications: [School-age children] Yes No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

By signing below, I certify that the child is authorized to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs.

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____