Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

Maryland State Department of Education — Preparing World Class Students

Triggers (list)

_____
_____
_____
_____
_____
_____

Student's

Name:_____ DOB:_____ PEAK FLOW PERSONAL BEST:_____

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

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

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

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: _____
- ☐ Peak flow greater than _____ (80% personal best)

☐ **Prior to exercise/sports/ physical education**

Medication	Dose	Route	Frequency
(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

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: _____
- ☐ Peak flow between _____ and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency

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

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or skin retracts between ribs
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: _____
- ☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

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. By signing below, I authorize 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. Student may self-carry medications:

(School-age children) ☐Yes ☐No

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

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

3/20/2014