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)

Medication	Dose	Route	Frequency
(Rescue Medication)			

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

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be <u>added</u> 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 <u>call 911</u>

☐ 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. 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:** _____