# 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 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