

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: _____ | Contact the parent/guardian after calling 911. | | | | |
| <input type="checkbox"/> Peak flow less than _____ (50% personal best) | | | | | |

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: _____