

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					
	<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					
	<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: \_\_\_\_\_