Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____	3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐ URI ☐ Seasonal Allergies ☐Pollen ☐ Exercise ☐Animals ☐Dust ☐Smoke ☐ Food ☐Weather ☐Other_____

6. **This authorization is NOT TO EXCEED 1 YEAR FROM____/____/____ TO ____/____/____**
FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Breathing is good ☐No cough or wheeze ☐Can walk, exercise, & play ☐Can sleep all night **If known, peak flow greater than _____ (80% personal best)**					

Exercise Zone ☐ CALL 911 ☐ CALL PARENT ☐ OTHER: _____

☐Prior to all exercise/sports ☐When the child feels they need it	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions

YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest ☐Cough or cold symptoms ☐Shortness of breath ☐Other:_____ **If known, peak flow between ____ and _____ (50% to 79% personal best)**					

RED ZONE - MEDICAL ALERT/DANGER ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐Breathing hard and fast ☐Lips or fingernails are blue ☐Trouble walking or talking ☐Medicine is not helping (15-20 mins?) ☐Other:_____ **If known, peak flow below _____ (0% to 49% personal best)**					

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CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ____/____/_____

Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

8. PRESCRIBER'S NAME/TITLE			Place Stamp Here
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION – MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: OK to Self-Carry/Self -Administer ☐ Yes ☐ No

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. CELL PHONE #	10e. HOME PHONE #	10f. WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:		
	1. Medication named above was received Expiration date _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐ N/A
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐ N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)