Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (not to exceed 12 months)

Triggers (list)
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____
____
____
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____

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

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: ______ ☐ Peak flow greater than ______ (80% personal best)				
☐ 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

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: ______				
☐ 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

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ 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)	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