HOLTON-ARMS SCHOOL

Health Notes for Upcoming 2022 – 2023 School Year

Holton-Arms School requires every student to have an annual physical examination and submit the completed Holton-Arms Health Forms to the school nurse, including changes or additions to the immunization record. All emergency contact information, consent to treat, and quick reference medical information, are to be completed online under re-enrollment/enrollment policies. As a reminder, Maryland State Law requires that all medication, both prescription and over-the-counter, be distributed through the school nurse's office; those forms are also included in the Health Form packet.

All Student Information and Emergency treatment are to be completed online in the Veracross database. Health Forms are located in the Magnus Health Portal (https://bit.ly/HAS_Magnus) using parent login and password.

- ☐ **Physician's Examination Form**: Next year's physical exam must be completed after August 1 of the previous year, regardless of the student's birth date. If you are unsure of the date of your daughter's last physical, please contact the school nurse.
- ☐ **Emergency Health Care Plan**: If your student has a severe allergy (requiring an EpiPen), asthma/RAD (requiring a rescue inhaler), diabetes, seizure disorder, or other serious medical condition requiring a plan of care, you must have your physician complete this form annually.
- ☐ **Over the Counter Medication Form**: If you would like the school nurse to administer the listed medications to your daughter during the school day, please have your physician complete and sign this form. This form must also be signed by a parent/guardian.
- ☐ **Maryland Immunization Certificate**: All new students, all rising sixth-grade students, and all rising ninth-grade students must submit a new, completed certificate and be up to date on all booster vaccinations. We do not accept religious or philosophical objections to vaccines. The only exceptions are medical exemptions with documentation from a medical provider on file. **We require all students above age 5 to have the entire Covid Vaccine series, to include a booster as applicable.**
- ☐ **Authorization to Administer Prescribed Medication**: All students who will be taking prescription medication of any kind, including over-the-counter medications. One form per medication must be completed.

For the 2022-2023 school year; forms will be due to the school by July 31.

Most pediatric practices fill their appointment books early for summer exams, so please make your appointment now. Students will not be allowed to attend August pre-season, camps, events, or school in September until all parts of the Health Form are submitted.

If you have any questions regarding the Health Form or other school health policies, please contact:

Lori Herringa, R.N., B.S.N., Director of Student Health
She/Her
301-365-6002

THE HOLTON-ARMS SCHOOL
7303 River Road • Bethesda, Maryland 20817

CLEARANCE FORM

Student's Name _____ Date of Birth _____ Grade _____

☐ Cleared for all PE, Sports & School Activities

☐ Cleared for all PE, Sports & School Activities with recommendations for further evaluation, limitations, or treatment for _____

_____

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For Any PE Sports
- ☐ For Certain Sports and Activities: _____

Reason: _____

Recommendations: _____

_____

_____

_____

_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s), physical education, or general activities of the school day. Any accommodations or restrictions have been outlined above. A copy of the physical exam should accompany this clearance and be kept at the school. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians.

Name of physician/nurse practitioner/physician's assistant (print) _____

Date _____ Address (or stamp) _____

_____

_____

Phone _____ Fax _____

Signature of physician/nurse practitioner/physician's assistant

_____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

THE HOLTON-ARMS SCHOOL
7303 River Road • Bethesda, Maryland 20817

THIS FORM IS DUE JULY 31 FOR ALL STUDENTS

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Student's Name _____ Date of Birth_____ Grade_____

Previous Medical History and/or Concerns: _____
_____
_____

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myyopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ , MD, DO, NP, or PA

Holton-Arms School Over the Counter (OTC) Medication Authorization Form

This form must be completed fully and on file in the Infirmary in order for a student to have OTC medications listed below provided by the school during a school day. A new and completed *Holton-Arms School OTC Medication Authorization Form* is required annually.

For non-prescription medication, not on the formulary list below, to be dispensed it must be in the unopened original container with the label intact and a Holton Medication Form, completed and signed by both physician and parent must accompany the medication.

The School Nurse (RN) will call the prescriber, as allowed by HIPAA/FERPA, if a question arises about the student and/or the student's medication(s).

Prescriber's Authorization

Name of student: _____ Date of Birth: _____ Grade: ___

***PLEASE CROSS OUT ANY PROHIBITED MEDICATIONS.**

Formulary List Medications	Dose	PRN for what symptoms	Special instructions
Acetaminophen Tablets 325 mg each		Pain, Fever >100	
Acetaminophen Pediatric Liquid		Pain, Fever >100	
Ibuprofen Tablets 200 mg each		Pain, Fever >100, inflammation	
Ibuprofen Pediatric Liquid		Pain, Fever >100, inflammation	
Diphenhydramine HCl Tablets 25 mg each		Itching, sneezing, congestion, allergic response	
Diphenhydramine HCl Liquid		Itching, sneezing, congestion, allergic response	
Tums >12 yrs old	2 tablets	Acid Indigestion	
Pepto Bismol Pediatric	2 tablets	Mild nausea, mild diarrhea	
Hydrocortisone 1% cream	topical	Itching	
Triple Antibiotic cream	topical	Cuts, scrapes	
Burn Gel	topical	1st degree burns only, lidocaine	
Throat Lozenges	1 lozenge	Coughing, sore throats	

Prescriber's Name:
Type or Print
Telephone: Fax:

Address:

Affix stamp here

Prescriber's Signature: Date:
(Original signature or signature stamp ONLY) Month/Day/Year

PARENT/GUARDIAN AUTHORIZATION

I/We request that our student and designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including self-administration of medication. I/We authorize the school nurse to communicate with the health care provided as allowed by HIPPA.

Parent/Guardian Signature: Date:

Reviewed and approved by the School Nurse:

Signature Date

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

HOLTON-ARMS SCHOOL
7303 River Road
Bethesda, MD 20817

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION
Release and Indemnification Agreement

PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Holton-Arms School personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless Holton-Arms School and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided Holton-Arms School staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student:_____ Birth date:__/__/____School:_____

Prescription: ☐ Renewal ☐ New If new, the first full day's dosage was given at home on:_____/___/____

List all medication(s) student is taking, including over-the-counter medication(s):_____

_____

_____ _____-_____-_____ _____/____/_____
Parent/Guardian Signature Phone Number Date

PART II – TO BE COMPLETED BY THE PHYSICIAN

The Holton-Arms School discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication:_____ Diagnosis:_____
Trade name and/or generic

Dosage:_____Time(s) To Be Given At School:_____

Route of Administration:_____ Effective Dates: From_____/____/___ To_____/___/____

Side Effects:

If PRN, specify:

When indicated (signs/symptoms)_____

Frequency of administration_____

_____ _____ _____-_____-_____ _____/___/___
Physician's Name (print/type) Physician Signature Phone Number Date

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of emergency medication such as inhalers and EpiPens® must be authorized by the prescriber and be approved by the school nurse according to the State medication policy:

Prescriber's authorization for self-carry/self-administration of emergency medication_____ _____/____/____
Signature Date

School RN approval for self-carry/self-administration of emergency medication_____ _____/____/____
Signature Date

PART III – TO BE COMPLETED BY SCHOOL NURSE

Check as appropriate:

☐ Parts I and II above are completed, including Signature. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank.)

☐ Prescription medication is properly labeled by a pharmacist.

☐ Medication label and physician order are consistent.

☐ Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

_____/____/_____ Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order).

_____ _____/____/_____
School Nurse Signature Date

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

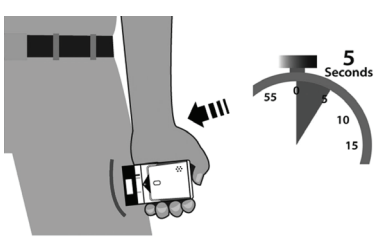
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

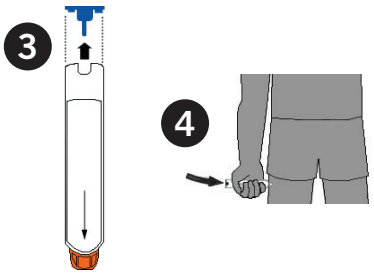
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



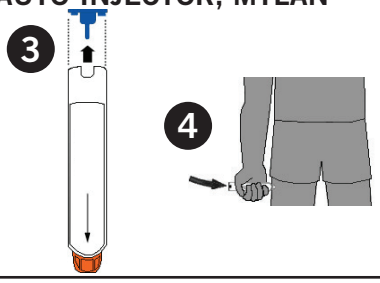
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



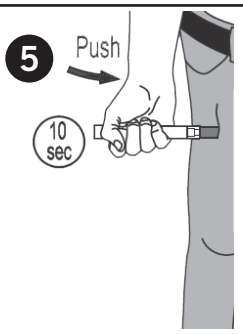
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

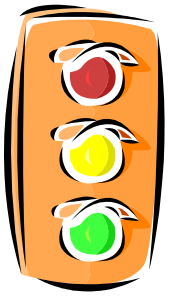
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

ASTHMA ACTION PLAN

Check Asthma Severity: ☐Mild Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: _____

Personal Peak Flow Ranges

RED means Danger Zone! Get help from a doctor. -- _____

YELLOW means Caution Zone! Add prescribed yellow medicine. -- _____

GREEN means Go Zone! Use preventive medicine. -- _____

GO (Green) → Use these medications every day.

You have *all* of these:
- Breathing is good.
- No cough or wheeze.
- Sleep through the night.
- Can work and play.

And/ or personal peak flow above 80 % _____

Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

CAUTION (Yellow) → Continue with green zone medicine and ADD:

You have *any* of these:
- First sign of a cold.
- Exposure to a known trigger.
- Cough.
- Mild wheeze.
- Tight chest.
- Cough at night.

And/ or personal peak flow from 80% _____ To 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

DANGER (Red) → Take these medicines and call your doctor.

Your asthma is getting worse fast:
- Medicine is not helping within 15-20 minutes.
- Breathing is hard and fast.
- Nose opens wide.
- Ribs show.
- Lips are blue.
- Fingernails are blue.
- Trouble walking or talking.

And/ or personal peak flow below 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Trigger List:
- ❑ Chalk dust
- ❑ Cigarette smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: _____ _____
- ❑ Other: _____

Adapted from: NYC DOHMH and Pediatric/ Adult Asthma Coalition of New Jersey.

www.fha.state.md.us/mch www.MarylandAsthmaControl.org www.mdaap.org

White Copy- Patient **Pink Copy- School** **Yellow Copy- Doctor**

DHMH Form Number: 4643

For additional forms, please call: 410-799-1940

How to Use this Form

The Asthma Action Plan is to be completed by a primary care provider for each individual (child or adult) that has been diagnosed with asthma. The Asthma Action Plan should be regularly modified to meet the changing needs of the patient and medicine regimes. The provider should be prepared to work with families to gain an understanding of how and when the Asthma Action Plan should be used. *Please complete all sections of the Asthma Action Plan. Please write legibly, and refrain from using abbreviations.*

The Asthma Action Plan is an education and communication tool to be used between the health care provider and the patient, with their family and caregivers, to properly manage asthma and respond to asthma episodes. The patient, and their family or caregivers, should fully understand the Asthma Action Plan, especially related to using the peak flow meter, recognizing warning signs, and administering medicines. Patients, families, and caregivers should be given additional educational materials related to asthma, peak flow monitoring, and environmental control.

Persons with asthma, parents, grandparents, extended family, neighbors, school staff, and childcare providers are among the persons that should use the Asthma Action Plan.

A spacer should be prescribed for all patients using a metered-dose inhaler (MDI).

Children ***over the age of six years*** may be given peak flow meters to monitor their asthma and determine the child's zone.
Parents of children ***under the age of six years*** should use symptoms to determine the child's zone.

Zone Instructions

The Personal Best peak flow should be determined when the child is symptom free. A diary can be used to determine personal best and is usually part of a peak flow meter package. A peak flow reading should be taken at all asthma visits and personal best should be redetermined regularly. Because peak flow meters vary in recording peak flow, please instruct your patients to bring their personal peak flow meter to every visit.

Green: Green Zone is 100 percent to 80 percent of personal peak flow best, or when no symptoms are present.
List all daily maintenance medicines. Fill in actual numbers, not percentages, for peak flow readings.

Yellow: Yellow zone is 80 percent to 50 percent of personal peak flow best, or when the listed symptoms are present.
Add medicines to be taken in the yellow zone and instruct the patient to continue with green zone (maintenance) medicines. Include **how long** to continue taking yellow (quick reliever) medicines and when to contact the provider.

Red: Red zone is 50 percent or below of personal peak flow best, or when the listed symptoms are present.
List any medicines to be taken while waiting to speak to a provider or preparing to go to the emergency room.

Peak Flow Chart

Green 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320
Yellow 80%	80	90	95	105	110	120	130	135	145	150	160	170	175	185	190	200	210	215	225	230	240	250	255
Red 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160

Green 100%	330	340	350	360	370	380	390	400	420	440	460	480	500	520	540	560	580	600	620	640	660	680	700
Yellow 80%	265	270	280	290	295	305	310	325	335	350	370	385	400	415	430	450	465	480	495	510	535	545	560
Red 50%	165	170	175	180	185	190	195	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350