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 _____/_____/_____**

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

FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

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)

OCC 1216 A REVISED SEPTEMBER 2022 – all previous editions are obsolete **PLEASE TURN OVER – THIS FORM HAS 2 SIDES WITH 4 TOTAL SECTIONS**

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

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

8. PRESCRIBER'S NAME/TITLE TELEPHONE ADDRESS			FAX			Place Stamp Here			
CITY			STATE		ZIP CODE				
9a. PRESCRIBER'S SIGNATU (Parent/guardian cannot s here)(original signature or 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)

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MEDICATIONADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child'sName:					**Date of Birth:**	
MEDICATION	**DATE**	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**
