

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)
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Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH 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 <u>ALL</u> 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: _____

The Child has <u>ANY</u> of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Prior to all exercise/sports ☐ When the child feels they need it					

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

The Child has <u>ANY</u> 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 <u>ANY</u> 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 _____ 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Form updated 4. OCC 1215 Health Inventory updated 5. Modified Diet/Exercise Plan 6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP 7. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No				
Reviewed by (printed name and signature):					DATE (mm/dd/yyyy)

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MEDICATION ADMINISTRATION 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's Name:					Date of Birth:	
MEDICATION	DATE	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE