Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN ____/____/____ (Date) to ____/____/____ (Date) (not to exceed 12 months)

TRIGGER (LIST)

Child's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS / INDICATIONS FOR MEDICATION USE

GREEN ZONE

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

☐ Prior to exercise/sports/ physical education (PE)

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.

YELLOW ZONE

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____
☐ Peak flow between _____ and _____ (50%-79% personal best)

RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

Medication	Dose	Route	Frequency/Time

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

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or intercostal retraction
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other: _____
☐ Peak flow less than _____ (50% personal best) _____

EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911.

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications ☐ Yes ☐ No

Health Care Provider Name: _____

Signature: _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child ☐ is ☐ is not authorized to self-carry his/her medication(s):

Signature: _____

Date: _____

REVIEWED BY SCHOOL NURSE

Name: _____

Signature: _____

Date: _____

Authorized to self-carry medications: ☐ Yes ☐ No

Asthma Action Plan (continued)

HEALTH LINK LLC

Camper's Name: _____ Date of Birth: _____

Counselor's Name: _____ Group: _____

Camp will:

- ☐ Have staff trained in medication administration onsite
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis, Asthma Signs & Symptoms, and Administration of Inhaler or Nebulizer
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to camp staff
- ☐ Have staff trained on individual emergency plans
- ☐ Ensure staff make every reasonable effort to prevent exposure to known allergens and Asthma triggers
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the camp
- ☐ Provide Physician Authorization Forms and Action Plans
  → for medication, and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Come to office to use inhaler prior to exercise
- ☐ Alert nearest adult if they experience any symptoms of Asthma (cough, wheezing, shortness of breath)
- ☐ If self-carrying and self-administering, camper will demonstrate responsibility by carrying their inhaler and notifying adult when they have used it, and committing to not sharing medication with any other person.

Notes:
