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)

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_____

Section I. ASTHMA ACTION PLAN

6. **FOR ASTHMA MEDICATIONS ONLY - THIS FORM REPLACES OCC 1216. This authorization is NOT TO EXCEED 1 YEAR**	6a. FROM ____/____/_____	6b. TO ____/____/_____

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated **OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer ☐ Yes ☐ No**

The Child has ALL of these	Medication Name	Dose	Route	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:_____** **OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer ☐ Yes ☐ No**

☐ Prior to all exercise/sports ☐ When the child feels they need it	Rescue Medication	Dose	Route	Frequency	Special Instructions

YELLOW ZONE - GETTING WORSE **☐CALL 911** **☐CALL PARENT** **☐OTHER:_____** **OK to Self-Carry ☐ Yes ☐ No** **OK to Self-Administer ☐ Yes ☐ No**

The Child has ANY of these	Medication Name	Dose	Route	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:_____** **OK to Self-Carry ☐ Yes ☐ No OK to Self-Administer ☐ Yes ☐ No**

The Child has ANY of these	Medication Name	Dose	Route	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

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

I request the authorized 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 Children Only) **OK to Self-Carry** ◯ **Yes** ◯ **No** **OK to 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

Child Care Responsibilities:				
	1. Medication named above was received	◯ Yes	◯ No	
	2. Medication labeled as required by COMAR	◯ Yes	◯ No	
	3. OCC 1214 Emergency Card updated	◯ Yes	◯ No	
	4. OCC 1215 Health Inventory updated	◯ Yes	◯ No	
	5. Modified Diet/Exercise Plan	◯ Yes	◯ No	◯ N/A
	6. Individualized Plan: IEP/IFSP	◯ Yes	◯ No	◯ N/A
	7. Medication Administration log attached to this form	◯ Yes	◯ No	
	8. Staff approved to administer medication is available onsite, field trips	◯ Yes	◯ No	

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)