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