Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form

ASThma ACTION PLAN for ___/__/___ to ___/__/___ (not to exceed 12 months)

**Student's Name:**
DOB: _______ PEAK FLOW PERSONAL BEST: _______

Asthma Severity: [ ] Exercise Induced [ ] Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent

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**Green Zone:** Long Term Control Medication — use daily at home unless otherwise indicated

- [ ] Breathing is good
- [ ] No cough or wheeze
- [ ] Can work, exercise, play
- Other: __________________________
- [ ] Peak flow greater than _________ (80% personal best)

- [ ] Prior to exercise/sports/physical education

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

**Yellow Zone:** Quick Relief Medications — to be added to Green zone medications for symptoms

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

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:** Emergency Medications — Take these medications and call 911

- [ ] Medication is not helping within 15-20 mins
- [ ] Breathing is hard and fast
- [ ] Nasal flaring or skin retracts between ribs
- [ ] Lips or fingernails blue
- [ ] Trouble walking or talking
- Other: __________________________
- [ ] Peak flow less than _________ (50% personal best)

Contact the parent/guardian after calling 911.

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**Health Care Provider and Parent Authorization**

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

(School-age children) [ ] Yes [ ] No

Prescriber signature: __________________________ Date: ________ Parent / Guardian Signature: __________________________ Date: ________

Reviewed by Child Care Provider: Name: __________________________ Signature: __________________________ Date: ________

3/20/2014