

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: _____

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

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:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1. Medication named above was received</td> <td style="width: 20%;">Expiration date _____</td> <td style="width: 30%;"> ☐ Yes ☐ No </td> </tr> <tr> <td>2. Medication labeled as required by COMAR</td> <td></td> <td> ☐ Yes ☐ No </td> </tr> <tr> <td>3. OCC 1214 Emergency Form updated</td> <td></td> <td> ☐ Yes ☐ No </td> </tr> <tr> <td>4. OCC 1215 Health Inventory updated</td> <td></td> <td> ☐ Yes ☐ No </td> </tr> <tr> <td>5. Modified Diet/Exercise Plan</td> <td></td> <td> ☐ Yes ☐ No ☐ N/A </td> </tr> <tr> <td>6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP</td> <td></td> <td> ☐ Yes ☐ No ☐ N/A </td> </tr> <tr> <td>7. Staff approved to administer medication is available onsite, field trips</td> <td></td> <td> ☐ Yes ☐ No </td> </tr> </table>					1. Medication named above was received	Expiration date _____	☐ Yes ☐ No	2. Medication labeled as required by COMAR		☐ Yes ☐ No	3. OCC 1214 Emergency Form updated		☐ Yes ☐ No	4. OCC 1215 Health Inventory updated		☐ Yes ☐ No	5. Modified Diet/Exercise Plan		☐ Yes ☐ No ☐ N/A	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP		☐ Yes ☐ No ☐ N/A	7. Staff approved to administer medication is available onsite, field trips		☐ Yes ☐ No
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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