

Maryland State School Asthma Medication Administration Authorization Form



ASTHMA ACTION PLAN _____ to _____ (not to exceed 12 months)
 Date Date

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 CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED					
	<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency/Time	<input type="checkbox"/> School
						<input type="checkbox"/> School
						<input type="checkbox"/> School
						<input type="checkbox"/> School
	EXERCISE ZONE					
	<input type="checkbox"/> 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 RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS					
	<input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	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 EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911						
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or intercostal retraction <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	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