Maryland State Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (or last day of summer school)

Triggers (list)

______
______
______
______
______
______
______

Student'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 medications — to be used daily

Symptoms	Medication	Dose	Route	Frequency
☐ 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**	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Rescue medications— to be added to Green zone medications for symptoms

Symptoms	Medication	Dose	Route	Frequency
☐ 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

Symptoms	Medication	Dose	Route	Frequency
☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or intercostal retractions ☐ Lips or fingernails blue				
☐ Trouble walking or talking ☐ Other: ________				
☐ Peak flow less than ________ (50% personal best)	**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:** ________

Address: ______________ **City:** ________ **Zip:** ________ **Tel:** ________ **Fax:** ________

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).

Parent /Guardian Signature: ______________ **Date:** ________

Reviewed by School Nurse: Name: ________ **Signature:** ________ **Date:** ______ **Authorized to self-carry medications:** ☐ **Yes** ☐ **No**