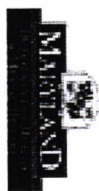


Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN _____ Date ____/____/____ to ____/____/____ (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											
<p>GREEN ZONE</p> <p><input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)</p>											
<p>EXERCISE ZONE</p> <p><input type="checkbox"/> Prior to exercise/sports/physical education (PE)</p>											
<p>YELLOW ZONE</p> <p><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 Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)</p>											
<p>RED ZONE</p> <p><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 Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)</p>											
<p>CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED</p> <table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Route</th> <th>Frequency/Time</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> School <input type="checkbox"/> School <input type="checkbox"/> School</td> </tr> </tbody> </table>				Medication	Dose	Route	Frequency/Time				<input type="checkbox"/> School <input type="checkbox"/> School <input type="checkbox"/> School
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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):

self-carry his/her medication(s): _____

Signature: _____

Date: _____

REVIEWED BY SCHOOL NURSE

Name: _____

Signature: _____

Date: _____

Authorized to self-carry medications: Yes No

Date: _____