

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
	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 NURSE

Name: _____

Signature: _____

Date: _____