

# 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

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		Medication (Rescue Medication)	Dose	Route	Frequency/Time
<input type="checkbox"/> Prior to exercise/sports/physical education (PE)					
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