

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)		2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____		3. Child's picture (optional)	
<p>Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER</p>					
<p>4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ____ %</p>					
<p>5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____</p>					
<p>6. This authorization is NOT TO EXCEED 1 YEAR FROM ____/____/____ TO ____/____/____ FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216</p>					
<p>GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated</p>					
<p>The Child has ALL of these</p>					
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night if known, peak flow greater than _____ (80% personal best)		Medication Name & Strength		Dose	
Exercise Zone <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it		Route		Time & Frequency	
Special Instructions		Route		Time & Frequency	
<p>YELLOW ZONE - GETTING WORSE <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____</p>					
<p>The Child has ANY of these</p>					
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ if known, peak flow between _____ and _____ (50% to 79% personal best)		Medication Name & Strength		Dose	
Special Instructions		Route		Time & Frequency	
<p>RED ZONE - MEDICAL ALERT/DANGER <input type="checkbox"/> CALL 911 <input type="checkbox"/> CALL PARENT <input type="checkbox"/> OTHER: _____</p>					
<p>The Child has ANY of these</p>					
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ if known, peak flow below _____ (0% to 49% personal best)		Medication Name & Strength		Dose	
Special Instructions		Route		Time & Frequency	

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CHILD'S NAME (First Middle Last) _____ DATE OF BIRTH (mm/dd/yyyy) ____/____/____

Section II. PRESCRIBER'S AUTHORIZATION - MUST BE COMPLETED BY THE HEALTH CARE PROVIDER
Place Stamp Here

8. PRESCRIBER'S NAME/TITLE _____

TELEPHONE _____ FAX _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
(original signature or signature stamp only) _____

9b. DATE (mm/dd/yyyy) _____

Section III. PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: OK to Self-Carry/Self-Administer Yes No

10a. PARENT/GUARDIAN SIGNATURE _____

10b. DATE (mm/dd/yyyy) _____

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION _____

10d. CELL PHONE # _____

10e. HOME PHONE # _____

10f. WORK PHONE # _____

Emergency Contact(s) Name/Relationship _____ Phone Number to be used in case of Emergency _____

Parent/Guardian 1 _____

Parent/Guardian 2 _____

Emergency 1 _____

Emergency 2 _____

Section IV. CHILD CARE STAFF USE ONLY - MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:

1. Medication named above was received: Expiration date _____ Yes No

2. Medication labeled as required by COMAR Yes No

3. OCC 1214 Emergency Form updated Yes No

4. OCC 1215 Health Inventory updated Yes No

5. Modified Diet/Exercise Plan Yes No N/A

6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP Yes No N/A

7. Staff approved to administer medication is available onsite, field trips Yes No

Reviewed by (printed name and signature): _____ DATE (mm/dd/yyyy) _____