Maryland State Department of Education
Office of Child Care

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)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐ URI ☐ Seasonal Allergies ☐Pollen ☐ Exercise ☐Animals ☐Dust ☐Smoke ☐ Food ☐Weather ☐Other_____

6. **FOR ASTHMA MEDICATIONS ONLY - This authorization is NOT TO EXCEED 1 YEAR**	6a. FROM ___/___/_____	6b. TO ___/___/_____

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated School Age only: OK to Self-Carry/ Self-Administer ☐ Yes ☐ No

The Child has ALL of these	**Medication Name**	**Dose**	**Route**	**Frequency**	**Special Instructions**
☐Breathing is good ☐No cough or wheeze ☐Can walk, exercise, & play ☐Can sleep all night **If known, peak flow greater than _____ (80% personal best)**					

Exercise Zone ☐ CALL 911 ☐ CALL PARENT ☐ OTHER: _____ School Age only: OK to Self-Carry /Self-Administer ☐ Yes ☐ No

☐Prior to all exercise/sports ☐When the child feels they need it	**Rescue Medication**	**Dose**	**Route**	**Frequency**	**Special Instructions**

YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____ School Age only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No

The Child has **ANY** of these	**Medication Name**	**Dose**	**Route**	**Frequency**	**Special Instructions**
☐Some problems breathing ☐Wheezing, noisy breathing ☐Tight chest ☐Cough or cold symptoms ☐Shortness of breath ☐Other:_____ **If known, peak flow between ____ and _____ (50% to 79% personal best)**					

RED ZONE - MEDICAL ALERT/DANGER ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:_____ School Age only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No

The Child has **ANY** of these	**Medication Name**	**Dose**	**Route**	**Frequency**	**Special Instructions**
☐Breathing hard and fast ☐Lips or fingernails are blue ☐Trouble walking or talking ☐Medicine is not helping (15-20 mins?) ☐Other:_____ **If known, peak flow below _____ (0% to 49% personal best)**					