# Maryland State Asthma Medication Administration School Authorization Form

## ASTHMA ACTION PLAN

For __/__/__ to __/__/__ (or last day of summer school)

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>DOB:</th>
<th>PEAK FLOW PERSONAL BEST:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian’s Name:</td>
<td>Home:</td>
<td>Work:</td>
</tr>
<tr>
<td></td>
<td>Cell:</td>
<td></td>
</tr>
</tbody>
</table>

**ASTHMA SEVERITY:**

- ☐ Exercise Induced
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

### GREEN ZONE: Controller medications — to be used daily

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
</table>

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: __________________________
- ☐ Peak flow greater than _______ (80% personal best)

**Rescue Medication**

*If using more than twice per week for exercise, notify the health care provider and parent/guardian.*

### YELLOW ZONE: Rescue medications — to be added to Green zone medications for symptoms

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
</table>

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: __________________________
- ☐ Peak flow between _____ and _____ (50%-79% personal best)

**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**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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</table>

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or intercostal retractions
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: __________________________
- ☐ Peak flow less than ___________ (50% personal best)

**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

<table>
<thead>
<tr>
<th>Health Care Provider Name:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>Zip:</th>
<th>Tel:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

### 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).

<table>
<thead>
<tr>
<th>Parent /Guardian Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Reviewed by School Nurse: Name: __________________________ Signature: __________________________ Date: __________ Authorized to self-carry medications: ☐ Yes ☐ No 12/2011