**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

Please complete both pages of this form if the child has an inhaler or other asthma-related medication.

1. **CHILD’S NAME** (First Middle Last)
   - [ ]

2. **DATE OF BIRTH** (mm/dd/yyyy)
   - [ ]

3. **PEAK FLOW PERSONAL BEST:**
   - [ ]

4. **ASTHMA SEVERITY** (check one):
   - [ ] Mild Intermittent
   - [ ] Mild Persistent
   - [ ] Moderate Persistent
   - [ ] Severe Persistent
   - [ ] Exercise Induced

5. **ASTHMA TRIGGERS** (check all that apply):
   - [ ] Colds
   - [ ] Exercise
   - [ ] Animals
   - [ ] Dust
   - [ ] Smoke
   - [ ] Food
   - [ ] Weather
   - [ ] Other________________________

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### Section I. ASTHMA ACTION PLAN

**GREEN ZONE - DOING WELL**

You have **ALL** of these

- 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**

**Rescue Medication**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**Known side effects:**

**YELLOW ZONE - GETTING WORSE**

You have **ANY** of these

- 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)

**Emergency Medication**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Known side effects:**

**RED ZONE - MEDICAL ALERT/DANGER**

You have **ANY** of these

- 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)

**Emergency Medication**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
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</table>

**Known side effects:**

**Keep for 3 Years**

MDH-4758-C (01/2019)

Please turn over - this form has 2 pages with four total sections
ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM
for Youth Camps in Maryland

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

Section II. PRESCRIBER’S AUTHORIZATION

8. PRESCRIBER’S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIP CODE

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)

9b. DATE (mm/dd/yyyy)

(original signature or signature stamp only)

Section III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. 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 camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

10a. PARENT/GUARDIAN SIGNATURE

10b. DATE (mm/dd/yyyy)

10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. HOME PHONE #

10e. CELL PHONE #

10f. WORK PHONE #

Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I: Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER’S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY

11b. DATE (mm/dd/yyyy)

12a. PARENT/GUARDIAN’S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY

12b. DATE (mm/dd/yyyy)

Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:

Reviewed by:

DATE (mm/dd/yyyy)

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Keep for 3 Years