

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 HEALTH 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. This authorization is NOT TO EXCEED 1 YEAR FROM ____/____/____ TO ____/____/____

FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer Yes No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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)				

Exercise Zone CALL 911 CALL PARENT OTHER: _____

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<input type="checkbox"/> Prior to all exercise/sports				
<input type="checkbox"/> When the child feels they need it				

YELLOW ZONE - GETTING WORSE CALL 911 CALL PARENT OTHER: _____

The Child has ANY of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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)				

RED ZONE - MEDICAL ALERT/DANGER CALL 911 CALL PARENT OTHER: _____

The Child has ANY of these

Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
<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)				

Maryland State Department of Education
Office of Child Care
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CHILD'S NAME (First Middle Last)

DATE OF BIRTH (mm/dd/yyyy) ____/____/____

8. PRESCRIBER'S NAME/TITLE

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

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

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)

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MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

MEDICATION ADMINISTRATION LOG						Child's Name: _____ Date of Birth: _____	
MEDICATION	DATE	TIME	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE	

OCC 1216A REVISED AUGUST 2022 – all previous editions are obsolete

