ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Page 1 of 2

Please complete both pages of 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

1. CHILD'S NAME (First Middle Last)			2. DATE OF BIRTH (mm/dd/y	ууу)	3. PEAK FLOW PERSO	NAL 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							
Section I. ASTHMA ACTION PLAN							
6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED 6a. FROM (mm/dd/yyyy) 6b. TO (mm/dd/yyyy)							
during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.							
GREEN ZONE - DOING WELL							
You have <u>ALL</u> of these	Medication Name	Dose	Route	Frequency	OK to Self-Administer		
Breathing is good					☐ Yes ☐ No		
No cough or wheeze		Known side	effects:				
Can walk, exercise, & play					☐ Yes ☐ No		
Can sleep all night		Known side	effects:		•		
If known, peak flow greater					☐ Yes ☐ No		
than (80% personal best)		Known side	effects:				
Exercise Zone							
	Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry	
☐ Prior to all exercise/sports					☐ Yes ☐ No	□ Yes □ No	
☐ When the child feels they need it		Known side	effects:				
YELLOW ZONE - GETTING WORSE							
You have <u>ANY</u> of these	Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry	
Some problems breathing					☐ Yes ☐ No	☐ Yes ☐ No	
Wheezing, noisy breathing Tight chest		Known side	effects:	•	•		
Cough or cold symptoms					☐ Yes ☐ No	☐ Yes ☐ No	
Shortness of breath		Known side	effects:				
Other: If known, peak flow between					☐ Yes ☐ No	☐ Yes ☐ No	
and (50% to 79% personal best)		Known side	effects:				
RED ZONE - MEDICAL ALERT/DANGER							
You have ANY of these	Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry	
Breathing hard and fast					☐ Yes ☐ No	☐ Yes ☐ No	
Lips or fingernails are blue		Known side	effects:		•		
Trouble walking or talking Medicine is not helping (15-20 mins?)					☐ Yes ☐ No	☐ Yes ☐ No	
Other:		Known side	effects:				
If known, peak flow below					☐ Yes ☐ No	☐ Yes ☐ No	
(0% to 49% personal best)		Known side	Known side effects:				

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Page 2 of 2

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Please complete this form if the child has an inhaler or other asthma-related medication (410) 767-8417 or 1-877-463-3464 ext. 78417 CHILD'S NAME (First Middle Last) DATE OF BIRTH (mm/dd/yyyy) Section II. PRESCRIBER'S AUTHORIZATION 8. PRESCRIBER'S NAME/TITLE This space may be used for the Prescriber's Address Stamp FAX TELEPHONE **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 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 o 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. 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." 11b. DATE (mm/dd/yyyy) 11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY 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: DATE (mm/dd/yyyy) Reviewed by: