ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

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

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________________

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED 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.	6a. FROM (mm/dd/yyyy) ___/___/_____	6b. TO (mm/dd/yyyy) ___/___/_____

GREEN ZONE - DOING WELL

You have ALL of these	Medication Name	Dose	Route	Frequency	OK to Self-Administer
Breathing is good No cough or wheeze					☐ Yes ☐ No
		Known side effects:			
Can walk, exercise, & play Can sleep all night					☐ Yes ☐ No
		Known side effects:			
If known, peak flow greater than _____ (80% personal best)					☐ Yes ☐ No
		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 ANY of these	Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
Some problems breathing Wheezing, noisy breathing					☐ Yes ☐ No	☐ Yes ☐ No
Tight chest		Known side effects:				
Cough or cold symptoms Shortness of breath					☐ Yes ☐ No	☐ Yes ☐ No
Other:______________		Known side effects:				
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 Trouble walking or talking		Known side effects:				
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 effects:				

Please turn over - this form has 2 pages with four total sections

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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
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

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)