# ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

**for Youth Camps in Maryland**



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/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
- 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 | Dose | Route | Frequency | OK to Self-Administer | OK to Self-Carry |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |

☐ Prior to all exercise/sports
☐ When the child feels they need it

### 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 | Dose | Route | Frequency | OK to Self-Administer | OK to Self-Carry |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *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 | Dose | Route | Frequency | OK to Self-Administer | OK to Self-Carry |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |
| | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | *Known side effects:* | | | | |

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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) |

Attention:

This form is only valid for summer camp programs.

Friends Community School Summer Camp generally accepts exisiting Medication Administration Forms from a child's current school if it is valid through the summer.

Currently enrolled FCS families:
- Please contact the school nurse to determine if your existing forms are valid.

If your child will be attending FCS this coming fall, please ask your physician to use the standard

Maryland State School Medication Administration Authorization form
AND
relevant allergy/asthma action plans

instead of this form as the camp form will not roll over to the academic year.