Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form

Student’s
Name: ______________________ DOB: ___________ PEAK FLOW PERSONAL BEST: ___________

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

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GREEN ZONE: Long Term Control Medication — use daily at home unless otherwise indicated

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
</table>

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: __________________________
☐ Peak flow greater than _________ (80% personal best)

☐ Prior to exercise/sports/physical education

(Rescue Medication)

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

<table>
<thead>
<tr>
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</table>

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: __________________________
☐ Peak flow between _______ and _______ (50%-79% personal best)

If symptoms do not improve in _______ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications — Take these medications and call 911

<table>
<thead>
<tr>
<th>Medication</th>
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</table>

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other: __________________________
☐ Peak flow less than _________ (50% personal best)

Contact the parent/guardian after calling 911.

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Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

(School-age children) ☐ Yes ☐ No

Prescriber signature: ______________________ Date: ___________ Parent/Guardian Signature: ______________________ Date: ___________

Reviewed by Child Care Provider: Name: ______________________ Signature: ______________________ Date: ___________

3/10/2014