**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.

### 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**.

**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**

**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**

**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)

**Known side effects:**

**MDH-4758-C (01/2019)**

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

Keep for 3 Years
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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)

9b. DATE (mm/dd/yyyy) (original signature or signature stamp only)

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)

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