

Maryland State Department of Education  
Office of Child Care

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM**

| 1. CHILD'S NAME (First Middle Last)   |  | 2. DATE OF BIRTH (mm/dd/yyyy) |      | 3. Child's picture (optional) |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|-------------------------------|------|-------------------------------|-----------|----------------------------|--|-----------------|------|-------|-----------|----------------------|---|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>Section I. ASTHMA ACTION PLAN - MUST BE COMPLETED BY THE HEALTH CARE PROVIDER</b>  |  |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ___ %   |  |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other  |  |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. FOR ASTHMA MEDICATIONS ONLY - This authorization is NOT TO EXCEED 1 YEAR   |  |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>(GREEN ZONE) - No symptoms, normal control of medication</span> <span>6a. FROM ___/___/___</span> <span>6b. TO ___/___/___</span> </div>   |  |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <input type="checkbox"/> Can walk, exercise, & play   | <input type="checkbox"/> Can sleep all night                                     |                               |      |                               |           |                            |  |                 |      |       |           |                      |   |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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