

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

CHILD'S NAME (First Middle Last)		DATE OF BIRTH (mm/dd/yyyy) ____/____/____															
Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER																	
8. PRESCRIBER'S NAME/TITLE		Place Stamp Here															
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 – MUST BE COMPLETED BY THE PARENT/GUARDIAN																	
<p>I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. 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 childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.</p> <p>School Age Child Only: OK to Self-Carry/Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
10a. PARENT/GUARDIAN SIGNATURE		10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION														
10d. CELL PHONE #	10e. HOME PHONE #		10f. WORK PHONE #														
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency															
Parent/Guardian 1																	
Parent/Guardian 2																	
Emergency 1																	
Emergency 2																	
Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM																	
Child Care Responsibilities:	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">1. Medication named above was received</td> <td style="width: 40%; text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td>2. Medication labeled as required by COMAR</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td>3. OCC 121A Emergency Card updated</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td>4. OCC 1215 Health Inventory updated</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td>5. Modified Diet/Exercise Plan</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> </tr> <tr> <td>6. Individualized Plan: IEP/IFSP</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> </tr> <tr> <td>7. Staff approved to administer medication is available onsite, field trips</td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>			1. Medication named above was received	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Medication labeled as required by COMAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. OCC 121A Emergency Card updated	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. OCC 1215 Health Inventory updated	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Modified Diet/Exercise Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	6. Individualized Plan: IEP/IFSP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	7. Staff approved to administer medication is available onsite, field trips	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)														