

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

CHILD'S NAME (First Middle Last)		DATE OF BIRTH (mm/dd/yyyy) ____/____/____			
<b>Section II. PRESCRIBER'S AUTHORIZATION - MUST BE COMPLETED BY THE HEALTH CARE PROVIDER</b>					
8. PRESCRIBER'S NAME/TITLE		Place Stamp Here			
TELEPHONE	FAX				
ADDRESS					
CITY	STATE				
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)					
<b>Section III. PARENT/GUARDIAN AUTHORIZATION - MUST BE COMPLETED BY THE PARENT/GUARDIAN</b>					
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.					
10a. PARENT/GUARDIAN SIGNATURE <input type="checkbox"/> Yes <input type="checkbox"/> No					
10d. CELL PHONE #	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION			
Emergency Contact(s)	10e. HOME PHONE #	10f. WORK PHONE #			
Parent/Guardian 1	Name/Relationship	Phone Number to be used in case of Emergency			
Parent/Guardian 2					
Emergency 1					
Emergency 2					
<b>Section IV. CHILD CARE STAFF USE ONLY - MUST BE COMPLETED BY THE CHILD CARE PROGRAM</b>					
Child Care Responsibilities:					
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 1214 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 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					
Reviewed by (printed name and signature):					DATE (mm/dd/yyyy)