Maryland State Child Care/N Asthma Medication Adminis ASTHMA ACTION PLAN for _	stration Authorization Form	E	VLAND STATE DEPARTMENT OF DUCATION ARING WORLD CLASS STUDENTS	Triggers (list)
tudent's		120		8 -
ame:DOB:	PEAK FLOW PERSONAL B	EST:	<u>8</u> 9	
THMA SEVERITY: Exercise Induced Intermitt	ent Mild Persistent Moderate Pe	ersistent Seve	re Persistent	8
GREEN ZONE : Long Term Control Medication –	use daily at home unless otherwise ind	licated	SCHOOL SECTION SECTIONS	
☐ Breathing is good	Medication	Dose	Route	Frequency
□ No cough or wheeze				
☐ Can work, exercise, play	9	1		
Other:				
Peak flow greater than(80% personal best)	(Danna Bandination)			
Drier to eversies (enerts / physical education	(Rescue Medication)			
Prior to exercise/sports/ physical education	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			
YELLOW ZONE: Quick Relief Medications — to I	oe <u>added</u> to Green zone medications for	symptoms		
☐ Cough or cold symptoms	Medication	Dose	Route	Frequency
☐ Wheezing	ş			
☐ Tight chest or shortness of breath		35		2
☐ Cough at night ☐ Other:	<u> </u>	: 6	- 1	2
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: ☐ Peak flow between and (50%-79% personal best) RED ZONE: Emergency Medications— Take the	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 the	se medications and call 911			
Madication is not halping within 15-20 mins	Medication	Dose	Route	Frequency
☐ Breathing is hard and fast				6 10 16
☐ 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.			
uthorize the child care provider to administer the abovild to self-carry/self-administer the medications indicate chool-age children)	에 보면 하면 있다면 하면 하면 하면 하면 보면 하면 있다면 하면	, I authorize to self-		
escriber signature:	Date: Parent / Guardian Signature:			Date:
viewed by Child Care Provider: Name:	Signature:			Date:
20/2014				