Page 1 of 2

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

**for Youth Camps in Maryland**

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

Please complete both pages of this form if the child has an inhaler or other asthma-related medication.

1. **CHILD'S NAME** (First Middle Last)  
2. **DATE OF BIRTH (mm/dd/yyyy)**  
3. **PEAK FLOW PERSONAL BEST:**

4. **ASTHMA SEVERITY** (check one):
   - [ ] Mild Intermittent
   - [ ] Mild Persistent
   - [ ] Moderate Persistent
   - [ ] Severe Persistent
   - [ ] Exercise Induced

5. **ASTHMA TRIGGERS** (check all that apply):
   - [ ] Colds
   - [ ] Exercise
   - [ ] Animals
   - [ ] Dust
   - [ ] Smoke
   - [ ] Food
   - [ ] Weather
   - [ ] Other ____________________

6. **THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED**  
6a. **FROM** (mm/dd/yyyy)  
6b. **TO** (mm/dd/yyyy)

**GREEN ZONE - DOING WELL**

You have **ALL** of these

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Exercise Zone**

- [ ] Prior to all exercise/sports
- [ ] When the child feels they need it

**YELLOW ZONE - GETTING WORSE**

You have **ANY** of these

<table>
<thead>
<tr>
<th>Emergency Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**RED ZONE - MEDICAL ALERT/DANGER**

You have **ANY** of these

<table>
<thead>
<tr>
<th>Emergency Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### Section II. PRESCRIBER'S AUTHORIZATION

8. PRESCRIBER'S NAME/TITLE

<table>
<thead>
<tr>
<th>TELEPHONE</th>
<th>FAX</th>
</tr>
</thead>
</table>

ADDRESS

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
</table>

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

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)

MDH-4758-C (01/2019) Please turn over - this form has 2 pages with four total sections Keep for 3 Years