Maryland State Department of Education
Office of Child Care
ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATIONN

Asthma Medication Authorization Form

Form 9

THE ROMAN CATHOLIC ARCHDIOCESE OF WASHING CATHOLIC SCHOOLS (MD/DC)

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____	3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced ☐ Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply) ☐ Colds ☐ URI ☐ Seasonal Allergies ☐ Pollen ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other _____

6. **This authorization is NOT TO EXCEED 1 YEAR FROM_____/_____/_____ TO _____/_____/_____**
FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Breathing is good ☐ No cough or wheeze ☐ Can walk, exercise, & play ☐ Can sleep all night **If known, peak flow greater than _____ (80% personal best)**					

Exercise Zone ☐ **CALL 911** ☐ **CALL PARENT** ☐ **OTHER: _____**

	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Prior to all exercise/sports ☐ When the child feels they need it					

YELLOW ZONE - GETTING WORSE ☐ **CALL 911** ☐ **CALL PARENT** ☐ **OTHER:_____**

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Some problems breathing ☐ Wheezing, noisy breathing ☐ Tight chest ☐ Cough or cold symptoms ☐ Shortness of breath ☐ Other:_____ **If known, peak flow between ____ and _____ (50% to 79% personal best)**					

RED ZONE - MEDICAL ALERT/DANGER ☐ **CALL 911** ☐ **CALL PARENT** ☐ **OTHER:_____**

The Child has ANY of these	Medication Name & Strength	Dose	Route	Time & Frequency	Special Instructions
☐ Breathing hard and fast ☐ Lips or fingernails are blue ☐ Trouble walking or talking ☐ Medicine is not helping (15-20 mins?) ☐ Other: _____ **If known, peak flow below _____ (0% to 49% personal best)**					

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

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.

School Age Child Only: OK to Self-Carry/Self -Administer ☐ Yes ☐ No

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:		
	1. Medication named above was received Expiration date _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐ N/A
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐ N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

MEDICATION ADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:					**Date of Birth:**	
MEDICATION	**DATE**	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

OCC 1216A REVISED AUGUST 2022 – all previous editions are obsolete

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

To be filled out by the parent or guardian

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here and in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.
2. Schools do NOT provide medication for students use.
3. Medication should be taken at home whenever possible. The first dose of any new medication must be given at home.
4. Medication Authorization forms are required for each prescription and over-the-counter (OTC) medication administered in school.
5. All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.
6. All Over the Counter (OTC) medication must be in the original, sealed container with the name of the medication and its expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    - Name of student
    - Exact dosage to be taken in school
    - Frequency or time interval dosage is to be administered
7. The parent or guardian must transport medications to and from school.
8. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
9. Parents/ guardians are responsible for submitting a new medication authorization form to the school at the beginning of the school year and each time there is a change in the dosage or the time of medication administration.
10. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.

    - Student name
    - Date of Birth
    - Diagnosis
    - Signs or symptoms
    - Name of medication to be given in school
    - Exact dosage to be taken in school
    - Route of medication
    - Common side effects
    - Time and frequency to give medications, as well as exact time interval for additional dosages
    - Sequence in which two or more medications are to be administered
    - Duration of medication order or effective start and end dates
    - LHCP's name, signature and telephone number
    - Date of order

11. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within the period will be destroyed.
14. Students are NOT permitted to self-medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on case-by-case basis for students who demonstrate the capability to self-administer emergency life-saving medications (e.g. inhaler, EpiPen)

I hereby request designated _____ personnel to administer an inhaler a directed by this
School Name
authorization. I agree to release, indemnify, and hold harmless the Roman Catholic Archdiocese of Washington, the parish, school personnel, employees, or agents from any lawsuit, claim, expense, demand or action, etc., against them for helping my child use an inhaler. I have read the procedures outlined above and assume responsibility as required. I am aware that the inhaler may be administered by a non-health professional.

Name of Parent/Gaurdian: _____ Phone: _____

Signature of Parent/ Guardian: _____ Date: _____

School Based Checklist: To be completed by principal and nurse

Student's Name: _____ Grade: _____ Teacher: _____

CHECKLIST FOR ASTHMA ACTION PLAN

Pages 1(Sections I and II) completed and signed by Licensed Health- Care Provider (LHCP)	☐ Yes	☐ No	
Page 2 (Section III) fully completed and signed by parent/guardian	☐ Yes	☐ No	
Page 2 (Section IV) fully completed and signed by child care/school staff	☐ Yes	☐ No	☐ N/A
Medication is appropriately labeled. The date one week after expiration of LHCP's order is:_____.	☐ Yes	☐ No	☐ N/A
Medication maintained in school designated area (Area:_____)	☐ Yes	☐ No	☐ N/A
***(If LHCP recommends that student self-carry)* Nurse has reviewed proper use of medication with student.**	☐ Yes	☐ No	☐ N/A
Copies of the Asthma Action Plan have been reviewed with and distributed to the following school personnel:			
Educational Support Agencies working with the student	☐ Yes	☐ No	☐ N/A
After-school program	☐ Yes	☐ No	☐ N/A
Coach/Athletic club supervisor	☐ Yes	☐ No	☐ N/A
Food Service provider	☐ Yes	☐ No	☐ N/A
Staff trained in medication administration	☐ Yes	☐ No	☐ N/A

Name:		Date Trained:		Location:	
Name:		Date Trained:		Location:	
Name:		Date Trained:		Location:	

EXPIRATION **of medication(s):**	

PRINCIPAL and NURSE APPROVAL

Name of Principal: _____

Signature of Principal: _____ Date: _____

Name of Nurse: _____

Signature of Nurse: _____ Date: _____