Please turn over - this form has 2 pages with your Total Sections

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Start Date (mm/dd/yyyy)</th>
<th>End Date (mm/dd/yyyy)</th>
<th>3. Peak Flow Personal Best: 66.10 (mmHg/mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rescue Medication</td>
<td>Route</td>
<td>Frequency</td>
<td>Dose</td>
</tr>
<tr>
<td>Emergency Medication</td>
<td>Route</td>
<td>Frequency</td>
<td>Dose</td>
</tr>
<tr>
<td>Red Zone - Medical Alert/Warning</td>
<td>Route</td>
<td>Frequency</td>
<td>Dose</td>
</tr>
<tr>
<td>Yellow Zone - Getting Worse</td>
<td>Route</td>
<td>Frequency</td>
<td>Dose</td>
</tr>
</tbody>
</table>

Section 1: Action Plan

4. Asthma Severity (check one): Yes | No
5. Asthma Triggers (check all that apply): Food | Exercise | Motion Sickness | Other

1. Child's Name (First Name Last)

2. Date of Birth (mm/dd/yyyy)

For youth camps in Maryland

Asthma Action Plan and Medication Administration Authorization Form

Office of Healthy Homes and Communities
Maryland Department of Health (MHDOH)
# ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

**for Youth Camps in Maryland**

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

<table>
<thead>
<tr>
<th>CHILD'S NAME (First Middle Last)</th>
<th>DATE OF BIRTH (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

## Section II. PRESCRIBER'S AUTHORIZATION

This space may be used for the Prescriber's Address Stamp

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

<table>
<thead>
<tr>
<th>ADDRESS</th>
</tr>
</thead>
</table>

<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)

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