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

[redacted]

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)

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CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ____/____/_____

8. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
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)

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 #

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)

Camp Medical Staff Notes:	
Reviewed by:	DATE (mm/dd/yyyy)