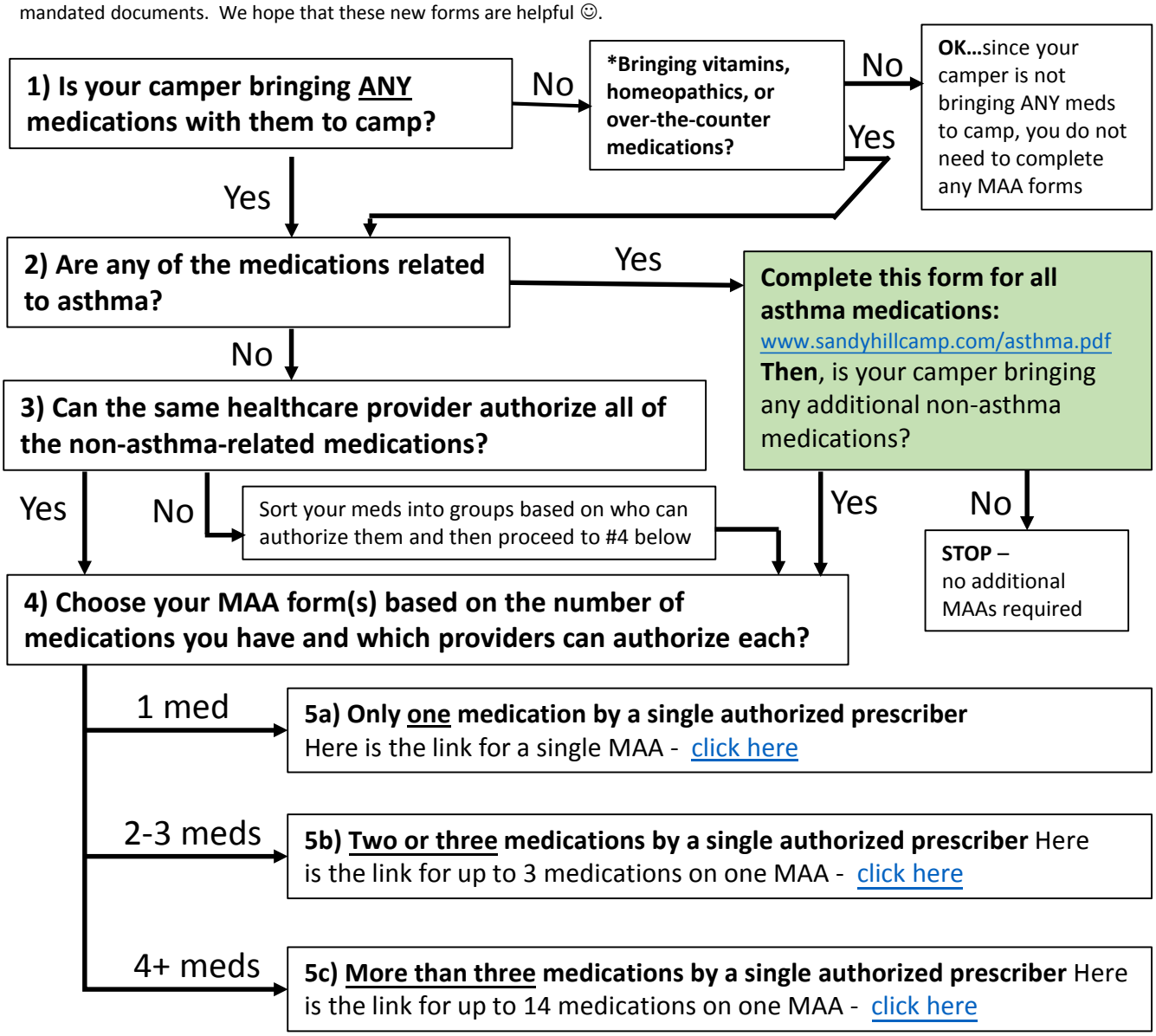
Do you have the right form? Let's make sure…

The form on the next 2 pages is a combination Asthma Action Plan plus a Medication Administration Authorization Form

We understand that some health care providers charge additional fees for each completed form. We now have multi-medication forms (see links below) in an effort to reduce the fees charged by some prescribers to complete these state-mandated documents. We hope that these new forms are helpful ☺.



*The state of Maryland requires all medications to be accompanied by a Medication Administration Authorization (MAA) form signed by a prescriber. This applies to all types of medications including prescription, over-the-counter, vitamins, and homeopathics.

Remember that Sandy Hill stocks over 30 commonly used over-the-counter medications including ibuprofen (Motrin, Advil), acetaminophen (Tylenol), diphenhydramine (Benadryl) and many more. If your camper needs any of these on an as-needed only basis, you do not need to complete any paper medication authorization forms – you simply need to provide parental permission in your camper's Online Health History found on their Camper Home Page.

For more information about medication at camp, please see Section 2.6 on page 7 of the Parents Handbook at www.sandyhill.com/find-a-form.

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

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

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
Please return this completed form to Sandy Hill Camp by fax to (410) 216-3375 or upload online via your Camper Home Page

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_____

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.	6a. FROM (mm/dd/yyyy) ____/____/_____	6b. TO (mm/dd/yyyy) ____/____/_____

GREEN ZONE - DOING WELL

You have **ALL** of these
- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- **If known, peak flow greater than _____ (80% personal best)**

Medication Name	Dose	Route	Frequency	OK to Self-Administer
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

Exercise Zone

Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

☐ Prior to all exercise/sports
☐ When the child feels they need it

YELLOW ZONE - GETTING WORSE

You have **ANY** of these
- 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)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these
- 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)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland **Page 2 of 2**

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

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
Please return this completed form to Sandy Hill Camp by fax to (410) 216-3375 or upload online via your Camper Home Page

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

Section II. PRESCRIBER'S AUTHORIZATION

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)

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)