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

1) Is your camper bringing ANY medications with them to camp?  
No

Yes

2) Are any of the medications related to asthma?  
Yes

No

3) Can the same healthcare provider authorize all of the non-asthma-related medications?  
Yes

No

Sort your meds into groups based on who can authorize them and then proceed to #4 below

4) Choose your MAA form(s) based on the number of medications you have and which providers can authorize each?

1 med

5a) Only one medication by a single authorized prescriber
Here is the link for a single MAA - click here

2-3 meds

5b) NEW two or three medications by a single authorized prescriber
Here is the link for up to 3 medications on one MAA - click here

4+ meds

5c) NEW more than three medications by a single authorized prescriber
Here is the link for up to 14 medications on one MAA - click here

*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.sandyhillcamp.com/parent_handbook_2018.pdf.
**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.

<table>
<thead>
<tr>
<th>1. CHILD’S NAME (First Middle Last)</th>
<th>2. DATE OF BIRTH (mm/dd/yyyy)</th>
<th>3. PEAK FLOW PERSONAL BEST:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

   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.

**Section I. ASTHMA ACTION PLAN**

**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>Breathing is good</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>No cough or wheeze</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Can walk, exercise, &amp; play</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Can sleep all night</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If known, peak flow greater than _____ (80% personal best)</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

**Exercise Zone**

<table>
<thead>
<tr>
<th>Rescue 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 □ No</td>
<td></td>
</tr>
</tbody>
</table>

**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>Some problems breathing</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Wheezing, noisy breathing</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Tight chest</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Cough or cold symptoms</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Other:_________________</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If known, peak flow between and _____ (50% to 79% personal best)</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></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>Breathing hard and fast</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Lips or fingernails are blue</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Trouble walking or talking</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Medicine is not helping (15-20 mins?)</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Other:_________________</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If known, peak flow below _____ (0% to 49% personal best)</td>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

Known side effects:

Known side effects:

Known side effects:

Known side effects:

Known side effects:

Known side effects:

Known side effects:
**Section II. PRESCRIBER’S AUTHORIZATION**

<table>
<thead>
<tr>
<th>8. PRESCRIBER’S NAME/TITLE</th>
<th>This space may be used for the Prescriber’s Address Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE</td>
<td>FAX</td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
</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.

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)