THIS FORM IS DUE
JUNE 30
FOR ALL STUDENTS

Holton-Arms School
7303 River Rd. Bethesda, MD 20817

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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CLEARANCE FORM 2019-2020

Student's Name_____ Date of Birth_____

☐ Cleared for all PE, Sports & School Activities

☐ Cleared for all PE, Sports & School Activities with recommendations for further evaluation, limitations, or treatment for_____

_____

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For Any PE and Sports
- ☐ For Certain Sports and Activities: _____

Reason:_____

Recommendations:

_____

_____

_____

_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s), physical education, or general activities of the school day. Any accommodations or restrictions have been outlined above. A copy of the physical exam should accompany this clearance and be kept at the school. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians.

Name of physician/nurse practitioner/physician's assistant (print)_____

Date_____ Address (or stamp)_____

_____

_____

Phone _____ Fax_____

Signature of physician/nurse practitioner/physician's assistant

_____

Holton-Arms School Over-the-Counter (OTC) Medication Authorization Form 2019-20

This form must be completed fully and on file in the Infirmary in order for a student to have formulary list OTC medication (see list below) provided by the school during a school day. A new and completed *Holton-Arms School OTC Medication Authorization Form* is required annually.

In order for non-prescription medication, not on the formulary list below, to be dispensed it must be in the unopened original container with the label intact and a Holton Medication Form, completed and signed by both physician and parent must accompany the medication.

The School Nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the student and/or the student's medication(s).

Prescriber's Authorization

Name of student: _____ Date of Birth: _____ Grade: ___

Please mark if the student CANNOT take this medication	Formulary List Medications	Dose	PRN for what symptoms	Relevant Side Effects	Special instructions
	Acetaminophen Tablets 325 mg each		Pain, Fever <100		
	Acetaminophen Pediatric Liquid		Pain, Fever <100		
	Ibuprofen Tablets 200 mg each		Pain, Fever <100, inflammation		
	Ibuprofen Pediatric Liquid		Pain, Fever <100, inflammation		
	Diphenhydramine HCl Tablets 25 mg each		Itching, sneezing, congestion, allergic response		
	Diphenhydramine HCl Liquid		Itching, sneezing, congestion, allergic response		
	Cramp tabs (Acetaminophen & Pamabrom)		Dysmenorrhea		
	Tums >12 yrs old	2 tablets	Acid Indigestion		
	Aluminum Hydroxide/Magnesium Hydroxide Tablets	2 tablets	Mild nausea, mild diarrhea		
	Hydrocortisone 1% cream	topical	Itching		
	Triple Antibiotic cream	topical	Cuts, scrapes		
	Medicaine Swabs	topical	Insect bites, itching		
	Mentholyptic Cough Lozenges	1 lozenge	Coughing, sore throats		

Prescriber's Name: _____
Type or Print

Telephone: _____ Fax: _____

Address: _____

_____

Affix stamp here

Prescriber's Signature: _____
(Original signature or signature stamp ONLY)

Date: _____
Month/Day/Year

Reviewed and approved by School Nurse: _____
Signature

_____
Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

HOLTON-ARMS SCHOOL
7303 River Road
Bethesda, MD 20817

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION
Release and Indemnification Agreement

PART I – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Holton-Arms School personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless Holton-Arms School and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided Holton-Arms School staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student:_____ Birth date:__/__/__School:_____

Prescription: ☐ Renewal ☐ New If new, the first full day's dosage was given at home on:__/__/____

List all medication(s) student is taking, including over-the-counter medication(s):_____

_____

_____ ____-____-____ ____/____/____
Parent/Guardian Signature *Phone Number* *Date*

PART II – TO BE COMPLETED BY THE PHYSICIAN

The Holton-Arms School discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication:_____ Diagnosis:_____
Trade name and/or generic

Dosage:_____Time(s) To Be Given At School:_____

Route of Administration:_____ Effective Dates: From____/____/____ To____/____/____

Side Effects:

If PRN, specify:

When indicated (signs/symptoms)_____

Frequency of administration_____

_____ _____ ____-____-____ ____/____/____
Physician's Name (print/type) *Physician Signature* *Phone Number* *Date*

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse according to the State medication policy:

Prescriber's authorization for self-carry/self-administration of emergency medication_____ ____/____/____
Signature *Date*

School RN approval for self-carry/self-administration of emergency medication_____ ____/____/____
Signature *Date*

PART III – TO BE COMPLETED BY THE ASSISTANT TO THE HEAD OF SCHOOL OR SCHOOL NURSE

Check as appropriate:

☐ Parts I and II above are completed, including Signature. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank.)

☐ Prescription medication is properly labeled by a pharmacist.

☐ Medication label and physician order are consistent.

☐ Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

____/____/____ Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order).

_____ ____/____/____
Assistant to the Head of School/School Nurse Signature *Date*

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

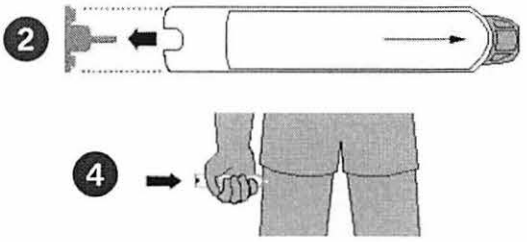
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

How to Use this Form

The Asthma Action Plan is to be completed by a primary care provider for each individual (child or adult) that has been diagnosed with asthma. The Asthma Action Plan should be regularly modified to meet the changing needs of the patient and medicine regimes. The provider should be prepared to work with families to gain an understanding of how and when the Asthma Action Plan should be used. *Please complete all sections of the Asthma Action Plan. Please write legibly, and refrain from using abbreviations.*

The Asthma Action Plan is an education and communication tool to be used between the health care provider and the patient, with their family and caregivers, to properly manage asthma and respond to asthma episodes. The patient, and their family or caregivers, should fully understand the Asthma Action Plan, especially related to using the peak flow meter, recognizing warning signs, and administering medicines. Patients, families, and caregivers should be given additional educational materials related to asthma, peak flow monitoring, and environmental control.

Persons with asthma, parents, grandparents, extended family, neighbors, school staff, and childcare providers are among the persons that should use the Asthma Action Plan.

A spacer should be prescribed for all patients using a metered-dose inhaler (MDI).

Children over the age of six years may be given peak flow meters to monitor their asthma and determine the child's zone.
Parents of children under the age of six years should use symptoms to determine the child's zone.

Zone Instructions

The Personal Best peak flow should be determined when the child is symptom free. A diary can be used to determine personal best and is usually part of a peak flow meter package. A peak flow reading should be taken at all asthma visits and personal best should be redetermined regularly. Because peak flow meters vary in recording peak flow, please instruct your patients to bring their personal peak flow meter to every visit.

Green: Green Zone is 100 percent to 80 percent of personal peak flow best, or when no symptoms are present.
List all daily maintenance medicines. Fill in actual numbers, not percentages, for peak flow readings.

Yellow: Yellow zone is 80 percent to 50 percent of personal peak flow best, or when the listed symptoms are present.
Add medicines to be taken in the yellow zone and instruct the patient to continue with green zone (maintenance) medicines. Include **how long** to continue taking yellow (quick reliever) medicines and when to contact the provider.

Red: Red zone is 50 percent or below of personal peak flow best, or when the listed symptoms are present.
List any medicines to be taken while waiting to speak to a provider or preparing to go to the emergency room.

Peak Flow Chart

Green 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320
Yellow 80%	80	90	95	105	110	120	130	135	145	150	160	170	175	185	190	200	210	215	225	230	240	250	255
Red 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160

Green 100%	330	340	350	360	370	380	390	400	420	440	460	480	500	520	540	560	580	600	620	640	660	680	700
Yellow 80%	265	270	280	290	295	305	310	325	335	350	370	385	400	415	430	450	465	480	495	510	535	545	560
Red 50%	165	170	175	180	185	190	195	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350

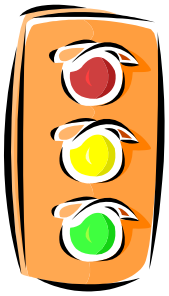
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

ASTHMA ACTION PLAN

Check Asthma Severity: ☐Mild Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: _____

Personal Peak Flow Ranges

RED means Danger Zone! Get help from a doctor. -- _____

YELLOW means Caution Zone! Add prescribed yellow medicine. -- _____

GREEN means Go Zone! Use preventive medicine. -- _____

GO (Green) → Use these medications every day.

You have *all* of these:
- Breathing is good.
- No cough or wheeze.
- Sleep through the night.
- Can work and play.

And/ or personal peak flow above 80 % _____

Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

CAUTION (Yellow) → Continue with green zone medicine and ADD:

You have *any* of these:
- First sign of a cold.
- Exposure to a known trigger.
- Cough.
- Mild wheeze.
- Tight chest.
- Cough at night.

And/ or personal peak flow from 80% _____ To 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

DANGER (Red) → Take these medicines and call your doctor.

Your asthma is getting worse fast:
- Medicine is not helping within 15-20 minutes.
- Breathing is hard and fast.
- Nose opens wide.
- Ribs show.
- Lips are blue.
- Fingernails are blue.
- Trouble walking or talking.

And/ or personal peak flow below 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Trigger List:
- ❑ Chalk dust
- ❑ Cigarette smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: _____ _____
- ❑ Other: _____

Adapted from: NYC DOHMH and Pediatric/ Adult Asthma Coalition of New Jersey.

www.fha.state.md.us/mch www.MarylandAsthmaControl.org www.mdaap.org

DHMH Form Number: 4643

For additional forms, please call: 410-799-1940