



SPRING LAKE PARK SCHOOLS

General Information

Name: _____ Date of birth: _____
 Emergency contact: _____ Phone number: _____
 Provider: _____ Phone number: _____
 May Self-Carry Medication/Inhaler: Yes No

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Premedication (how much and when) _____ _____ 2. Exercise modifications _____

Green Zone: Doing Well		Peak Flow Meter Personal Best =												
Symptoms <input checked="" type="checkbox"/> Breathing is good <input checked="" type="checkbox"/> No cough or wheeze <input checked="" type="checkbox"/> Can work and play <input checked="" type="checkbox"/> Sleeps well at night	Control Medications: <table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Medicine	How Much to Take	When to Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____ More than 80% of personal best or _____
Medicine	How Much to Take	When to Take It												
_____	_____	_____												
_____	_____	_____												
_____	_____	_____												

Yellow Zone: Getting Worse		Contact physician if using quick relief more than 2 times per week.									
Symptoms <input checked="" type="checkbox"/> Some problems breathing <input checked="" type="checkbox"/> Cough, wheeze, or chest tight <input checked="" type="checkbox"/> Problems working or playing <input checked="" type="checkbox"/> Wake at night	Continue control medicines and add: <table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Medicine	How Much to Take	When to Take It	_____	_____	_____	_____	_____	_____	IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days. <input type="radio"/> Change your long-term control medicine by _____ <input type="radio"/> Contact your physician for follow-up care.
Medicine	How Much to Take	When to Take It									
_____	_____	_____									
_____	_____	_____									
Peak Flow Meter Between 50% and 80% of personal best or _____ to _____	IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN <input type="radio"/> Take quick-relief treatment again. <input type="radio"/> Change your long-term control medicine by _____ <input type="radio"/> Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.										

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if:

- Still in the red zone after 15 minutes.
- You have not been able to reach your physician/healthcare provider for help.
- _____

Call an ambulance immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath.
- Lips or fingernails are blue.

Parent Signature: _____	Date: _____
Provider Signature: _____	Date: _____

Student Agreement:

I agree to:

- Follow my prescribing health professional's medication orders
- Use correct medication administration techniques
- Maintain a written record of my medication administration at school
- Not allow anyone else to use my medication
- Keep a supply of my medication with me in school and on field trips
- Notify the school nurse or health office personnel if the following occurs:
 - My symptoms continue to get worse after taking the medication
 - My symptoms reoccur within 2-3 hours after taking the medication
 - I suspect that I am experiencing side effects from my medication
 - Other: _____
- I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

Signature of Student

Date