

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
 School Name: \_\_\_\_\_ School Contact Phone #: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Phone #: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Emergency Phone #:** \_\_\_\_\_  
 Health Care Provider Name: \_\_\_\_\_ Health Care Provider Phone #: \_\_\_\_\_

To be completed by health care provider: **Asthma Severity:**  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

**Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.**

Asthma symptoms are triggered by:  Exercise  Dust  Animal dander  Strong Odors or Fumes  Mold  \_\_\_\_\_

**Green Zone**

**Personal Best Peak Flow (PF)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Peak flow is between \_\_\_\_\_ (80% of personal best) and \_\_\_\_\_ (100% of personal best)

**1. Take CONTROLLER medication(s) (at home) EVERY DAY:**

Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often

Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often

If asthma is triggered by exercise, take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs at least \_\_\_\_\_ minutes before exercise. Restrictions or activity limitations: \_\_\_\_\_  
Name of Medicine How much

**Yellow Zone-Caution! DO NOT LEAVE STUDENT ALONE!**

Peak flow is between \_\_\_\_\_ (50% of personal best) and \_\_\_\_\_ (80% of personal best).

**1. Begin QUICK RELIEF medication (at school or home) right NOW:**

Take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs OR \_\_\_\_\_ solution \_\_\_\_\_ ml by nebulizer.  
Name of Medicine How much Name of Medicine How much

- If symptoms are better or if the peak flow is back in the *Green Zone* within  15 minutes/ \_\_\_\_\_ minutes, THEN repeat QUICK RELIEF MEDICATION (as listed above in 1) every \_\_\_\_\_ hours.
- If symptoms are **NOT** better or if the peak flow is **NOT** improved, go to Red Zone.  
 **Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.**

**2. Attention Parent/Guardian (Home Instructions):**

- Call your child's Health Care Provider
- Continue to take CONTROLLER medication (at home) everyday as written above in *Green Zone* instructions.
- Increase CONTROLLER medication:

Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often

**Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below \_\_\_\_\_ (50% of personal best).**

**1. Take QUICK RELIEF medication (at school or home) right NOW:**

Take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs OR \_\_\_\_\_ solution \_\_\_\_\_ ml by nebulizer and **REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE!**  
Name of Medicine How much Name of Medicine How much

- **Call 9-1-1 immediately and call Parent/Guardian**

**2. Attention Parent/Guardian (Home Instructions):**

- Call your child's Health Care Provider.  Continue CONTROLLER medication (at home):

Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often

And ADD \_\_\_\_\_ mg orally once daily for \_\_\_\_\_ days.  
Name of Medicine How much Number

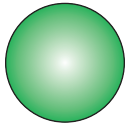
**Authorization from Parent/Guardian:** I have read and signed the attached *Authorization Form* so my child's Health Care Provider can share important information about my child's asthma to his/her school. My child is able to carry and self-administer asthma medications: Yes  No

\_\_\_\_\_  
Parent/Guardian Signature Date

**Health Care Provider:** My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student is able to self-administer asthma medications: Yes  No  (This authorization is for a maximum of one year from signature date.)

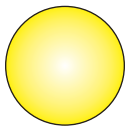
\_\_\_\_\_  
Healthcare Provider Signature Date

# Using Symptoms and/or Peak Flow to Know Your Zone



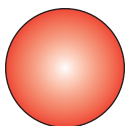
## Green Zone

- ✓ No cough or wheeze at day or night.
  - ✓ No chest tightness.
- OR
- ✓ **Peak flow** is between \_\_\_\_\_ (80% of personal best) and \_\_\_\_\_ (100% of personal best).



## Yellow Zone - Caution!

- Any asthma symptoms:
- ✓ Cough or wheeze at day or night.
  - ✓ Chest tightness.
  - ✓ Problems playing.
  - ✓ Waking at night with asthma symptoms.
- OR
- ✓ **Peak flow** is between \_\_\_\_\_ (50% of personal best) and \_\_\_\_\_ (80% of personal best).



## Red Zone - Medical Alert!

- Any asthma symptoms:
- ✓ Persistent cough or wheeze.
  - ✓ Severe chest tightness.
  - ✓ Can not walk, talk, or move well.
  - ✓ Blue skin color around lips or nails.
- OR
- ✓ **Peak flow** is below \_\_\_\_\_ (50% of personal best).

