

STUDENT

First: _____

Last: _____

DOB: _____ Grade: _____

Emergency Contact Name: _____ Number: _____
 (other than parent)

→ PARENT SIGNATURE: _____ DATE: _____

PARENT

Parent's Names: _____

Father Cell: _____

Mother Cell: _____

TO BE COMPLETED BY PHYSICIAN

TRIGGERS:

 Pollen Dust Mites Smoke

 Exercise Weather Food

 Mold Animals Other: _____

 Cold/Flu Air pollution

ASTHMA SEVERITY CLASSIFICATION:

 Intermittent

 Mild Persistent

 Moderate Persistent

 Severe Persistent

EXERCISE PRE-TREATMENT:

 Not required

 Before Recess (select treatment to the right) →

 Before P.E./Sports (select treatment to the right) →

GIVE THE STUDENT:

 Medicine: _____

 How much: _____

 _____ minutes prior to exercise

GREEN ZONE - ALL CLEAR - GO! - ASTHMA IS WELL CONTROLLED

If checked, no controlled medicine at this time.

- Symptoms:**
- Breathing is easy
 - No cough or wheeze
 - Can do usual activities
 - Can sleep through the night

If checked, please monitor peak flow.
 Peak flow from _____ to _____

MEDICINE	METHOD	DOSE	HOW OFTEN
			_____ times per day
			_____ times per day

YELLOW ZONE - CAUTION - TAKEN ACTION - ASTHMA IS GETTING WORSE, Continue green zone daily medications and...

- Symptoms:**
- Some shortness of breath
 - Cough, wheeze or chest tightness
 - Some difficulty doing usual activities
 - Sleep disturbed by symptoms
 - Symptoms of a cold or flu

If checked, please monitor peak flow.
 Peak flow from _____ to _____

MEDICINE	METHOD	DOSE	HOW OFTEN (circle one)
			Q _____ min/hr/day
			Q _____ min/hr/day

Alert parent to call doctor if yellow zone symptoms continue for 24 hours or if a child needs extra rescue medicine more than two times per week.

RED ZONE - STOP! - GET HELP NOW - TAKE QUICK RELIEF MEDICINE

- Symptoms:**
- Severe breathing problems
 - Chest and neck pulled in with each breath
 - Cannot do usual activities
 - Difficulty walking or talking
 - Rescue medicine is not helping

If checked, please monitor peak flow.
 Peak flow from _____ to _____ OR peak flow less than _____

THIS IS AN EMERGENCY! CALL 911

Continue green zone medicines and do the following:

_____ puffs of Albuterol/Xopenex - Q _____ min

one vial of Albuterol/Xopenex
 Inhaled every 20 minutes for a total of _____ doses.

→ **IF CHECKED STUDENT WILL SELF-CARRY INHALER. (Lower School students must supply emergency medicine to the health room.)**
 This student is capable and has been instructed in the proper method of self-administering medications named above. If checked this student will self carry emergency medicine throughout the school day and during all field trips. **ALL** middle and upper school students are responsible for self carrying emergency medicine during after school activities and overnight field trips, including sports, clubs, Winterim, Senior Trip and all summer activities/camps.) Student and/or parent will notify teachers, coaches, chaperones and school nurses emergency where medication will be located. All students are encouraged to provide an additional emergency medication to the health room.

→ PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME PRINTED: _____ PHONE: _____

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY THE LAST DAY OF SCHOOL.
THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.