



Student Name:	DOB:	School:
Parent/Guardian 1:	Phone:	
Parent/Guardian 2:	Phone:	
Provider:	Phone:	Fax:
Clinic:	Preferred Hospital:	
Allergies:		

Asthma Information (completed by the healthcare provider)

Severity	<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent
Triggers	<input type="checkbox"/> Viral respiratory infections <input type="checkbox"/> Exercise <input type="checkbox"/> Weather <input type="checkbox"/> Other: _____
Symptoms	<input type="checkbox"/> Cough <input type="checkbox"/> Wheeze <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest tightness <input type="checkbox"/> Other: _____

<p>Green Zone "OK"</p> <p>-Breathing is good -No cough or wheeze -Can work/play easily</p>	Daily Medicine	How much	How often
	<input type="checkbox"/> 10-15 minutes before high aerobic activity or cold air exposure Medicine: _____ How much: _____		
<p>Yellow Zone "CAUTION"</p> <p>-Breathing with some difficulty -Coughing, wheezing, chest tightness -Cannot work/play easily -Anxious</p>	At first symptoms, continue Green Zone medication and start:		
	Medicine	How much	How often
<p>For rapid increase in symptoms or rescue medication not giving relief for ___ hours → RED ZONE.</p>			
<p>Red Zone "DANGER"</p> <p>-Very hard to breathe -Nostrils flaring -Ribs are showing -Trouble walking/talking (unable to speak in full sentences) -Lips/fingers are gray or bluish</p>	<ol style="list-style-type: none"> 1. Take Yellow Zone medications if they haven't already been taken. 2. Notify parents and call 911. 3. Notify LSN if not already aware. 4. Keep the student calm and have them sit in a tripod position doing pursed lip breathing. 		

● I request that the above medication/treatment be administered to my student as prescribed by the healthcare provider. I release school personnel from liability in the event adverse reactions result from taking the medication(s). ● I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration. ● I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse. ● I understand and authorize my child's healthcare provider to release or share my child's protected health information regarding this medication and/or medical condition. ● If my student has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my student. I will notify the Health Office if I prefer to pick it up. All controlled substances will need to be picked up. If medication is left over and not picked up within 2 weeks after expiration or conclusion of the school year, it will be disposed of. ● I will immediately notify Health Services of any change in the medication(s) i.e dose change, medication, discontinued, etc. ● I understand it is my responsibility to notify the transportation company directly of any specific directions for my student's care while riding transportation before or after school.

*This student has been trained and is capable to carry and self administer (Gr. 5-12 only): yes no

Provider Signature: _____ Date: _____

Parent Signature: _____ Date: _____