PART I (To be filled out by parents/guardians)

Student Name: _____ Grade: _____ Homeroom: _____ Date of Birth: _____

Parent/Guardian: _____ Phone # _____ Work # _____ Other: _____

Parent/Guardian: _____ Phone # _____ Work # _____ Other: _____

Emergency Contact with transportation: _____ Phone # _____ Other: _____

Other: _____ Relationship to Student: _____ Phone # _____

Physician/PA/NP treating student: _____ Phone # _____

May contact Physician/PA/NP: ☐ Yes ☐ No

Identify things that start an asthma episode: _____

Identify changes required in school environment for student: _____

PART II (To be filled out by Physician/PA/NP)

GREEN ZONE= GO! (Good Breathing, No Cough or Wheeze, Able to Exercise, Good Sleep) **Peak flow** is _____ to _____

ACTIONS: * **Continue with daily or controller medicine:** Spacer must be used. ☐ **Yes** ☐ **No**

Name: _____ Dosage: _____ When: _____

Name: _____ Dosage: _____ When: _____

Name: _____ Dosage: _____ When: _____

☐ Take this medicine, _____, _____ mins before exercise or play. Dosage: _____

☐ Activity restrictions: ***There are none in this zone. P.E./Recess/Athletics are okay!***

YELLOW ZONE=CAUTION! (Some Coughing or Wheezing, Increased Symptoms upon Awakening, Waking at Night due to Asthma, Short of Breath while Resting, Some Activity Restrictions) Spacer must be used. ☐ **Yes** ☐ **No**

ACTIONS: Keep taking green zone medications **AND** Use your quick relief or rescue medicine. Peak flow is _____ to _____

Name: _____ Dosage: _____ When: _____

☐ Take (or increase) Anti-Inflammatory _____ to _____ puffs _____ times a day.

☐ _____

☐ _____

Continue Yellow Zone Plan until: _____

If asthma symptoms do not improve in 30 minutes or peak flow stays in the Yellow Zone after using the quick relief or rescue medicine, contact parent and go to **RED Zone NOW!**

THIS CHILD MUST GO HOME OR TO THE EMERGENCY ROOM NOW!

RED ZONE= STOP! Emergency Care Zone. GET HELP FROM PHYSICIAN/NP NOW! (Medicine is not helping, Breathing is hard and fast

Nose opens wide, Can't Walk, Ribs Show, Can't Talk Well.) Spacer must be used. ☐ **Yes** ☐ **No**

ACTIONS: CALL 911/EMERGENCY MEDICAL SERVICES (EMS) IMMEDIATELY! Peak flow is _____ to _____

* RIGHT NOW: Use your quick relief (bronchodilator) medicine.
  Name: _____ Dosage: _____
* Take oral anti-inflammatory: _____ Dosage: _____
* ☐ EpiPen or EpiPen Jr. , if also food allergic.

INSTRUCTIONS FROM PHYSICAN/PA/NP:

- ☐ I have instructed the above student in the proper use of all his/her asthma medications and in my opinion, the student should be able to carry and use his/her inhaler while at school.
- ☐ Student is to notify his/her teacher/aide, nurse or designated school health official after using inhaler.
- ☐ In my opinion, the student should not be able to carry and use his/her inhaler while at school.
- * **Authorization to carry the inhaler may be revoked if used inappropriately at any point during the school year.**

Physician/PA/NP Signature: _____ Date: _____

PARENT/GUARDIAN PERMISSION: Signing below gives my permission to use the above plan to manage my child's asthma.

Parent/Guardian Signature: _____ Date: _____

Health Services Signature: _____ Date: _____