



Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Medication Allergies: \_\_\_\_\_

Activities student participates in at school: \_\_\_\_\_

Asthma symptoms are triggered by:  Exercise  Illness  Pollen  Smoke  Air Pollution  Animals  Cold Air  Molds  Foods (list) \_\_\_\_\_

Please list any other triggers: \_\_\_\_\_

Usual Asthma Symptoms:  Cough  Shortness of Breath  Chest Tightness  Wheeze  Other (list) \_\_\_\_\_

**If a student has any of the following symptoms:** chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath:

- Stop activity & help student to a sitting position**
- Stay calm, reassure student**
- Assist student with the use of their inhaler**
- Escort student to the school clinic or call for nurse for immediate assistance. Never send the student to the clinic alone!**

**INHALER IS KEPT:**  In School Clinic  Self Carry

**CALL 911 FOR ANY OF THESE!**

- If breathing does not improve after medication is given**
- Student is having trouble walking or talking**
- Student is struggling to breathe**
- Student's chest and/ or neck is pulling in while breathing**
- Student's lips are blue, and/ or**
- Student must hunch over to breathe**

**HEALTH CARE PROVIDER, Please complete all items in box:** ICD Code:  493.9 or \_\_\_\_\_

Asthma Severity:  Intermittent  Mild persistent  Moderate persistent  Severe persistent

**Controller Medication given at home:**

Name of Medication 1/ how much? / How often? \_\_\_\_\_

Name of Medication 2/ how much? / How often? \_\_\_\_\_

**G R E E N Z O N E**

\*Peak Flow \_\_\_\_\_  
80 to 100% of personal best

**Asthma Symptoms**

- No Cough, wheeze or shortness of breath
- Able to do all normal activities including exercise and play
- No symptoms at night
- No need for quick relief medications for symptoms

**Use daily controller medications. Use quick relief inhaler before exercise as ordered below:**

\_\_\_\_\_  
Name of Medication 1/ how much? / How often?

**Y E L L O Z O N E**

\*Peak Flow \_\_\_\_\_  
50 to 80% of personal best

**Asthma Symptoms**

- Coughing, wheeze or shortness of breath, or chest tightness
- Using quick relief medication more than usual
- Can do some but not all of usual
- Asthma symptoms at night

**Add or change medications (see below).**

\_\_\_\_\_  
Name of Medication 1/ how much? / How often?

2 or  4 puffs, every 20 minutes for up to 1 hour

Nebulizer \_\_\_\_\_

Parent/ guardian –call medical provider if using quick relief medication more than twice a week or no symptom improvement

**R E D Z O N E**

\*Peak Flow \_\_\_\_\_  
Less than 50% of personal best

**Asthma Symptoms**

- Medication unavailable or not working
- Getting worse not better
- Breathing hard and fast
- Chest/neck pulling in
- Difficulty walking or talking
- Lips or fingernails blue
- Hunched over to breathe

**Take Quick Relief Medication Now!**  
**Call 911 & continue to give Quick Relief Medication every 20 minutes until EMS arrives!**

\_\_\_\_\_  
 4  6 puffs

\_\_\_\_\_  
Name of Medication 1/ how much? / How often?

Nebulizer \_\_\_\_\_

Other Emergency meds \_\_\_\_\_  
Contact Parent & Provider-See Contact Info Below

Student can self carry medication? Yes  No  Student can self-administer medication? Yes  No

Provider signature \_\_\_\_\_ Date \_\_\_\_\_ Provider printed name: \_\_\_\_\_

Provider Phone \_\_\_\_\_ Provider Fax: \_\_\_\_\_ Provider email \_\_\_\_\_

\*Peak flow reading may be obtained by the school RN in the school clinic. Implementation of these orders and care includes authorization to contact and discuss this conditions and elements of care with healthcare providers I have reviewed this Health Care Plan and I give permission for my child to participate in asthma education classes & give consent to the nurse to discuss medical concerns with the physician.

Parent/ Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_  
School Nurse Signature \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_