



PARENT SECTION

Student Last Name: _____ First Name: _____
 Date of Birth (mm/dd/yyyy): _____ School: _____ Grade: _____
 Parent/Guardian Name: _____ Parent/Guardian Signature: _____
 Emergency Phone: _____

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

<p>GREEN ZONE - Good control</p> <ul style="list-style-type: none"> No Cough or wheeze Tolerating activity easily <p>Peak flow above _____ Indicates that student's asthma is under good control. This is where he/she should be every day.</p>	<p>Treatment Plan:</p> <ol style="list-style-type: none"> Daily School Meds: Circle one: Albuterol / Other: _____ Use before exercise / physical activity: Yes ____ No ____ Other: _____
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<p>YELLOW ZONE - Worsening Asthma</p> <ul style="list-style-type: none"> Worsening symptoms: cough, wheeze, tight chest More short of breath with activity Need reliever inhaler more often than usual <p style="text-align: center;">OR</p> <p>Peak flow between _____ and _____ Indicates a warning that student's asthma may flare unless additional measures are taken.</p>	<p>Treatment Plan:</p> <ol style="list-style-type: none"> Reliever inhaler: Circle one: Albuterol / Other: _____ Recheck peak flow 10 minutes after treatment. May return to class if symptoms or peak flow improve. Vigorous activity should be avoided. May repeat inhaler if no improvement in 20 min: Yes ____ No ____ Call parent to inform of situation. If student is not improving or getting worse, follow Red Zone plan.
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<p>RED ZONE - Danger zone</p> <ul style="list-style-type: none"> Difficulty Breathing Getting little relief from inhalers Difficulty conversing Lips and fingernails blue Peak flow below _____ More breathless despite increased medications. Peak flows do not respond to reliever inhaler / nebulizer <p style="text-align: center;">This is student's danger zone.</p>	<p>Treatment Plan:</p> <ol style="list-style-type: none"> Call parent to inform of urgent situation. If symptoms continue to be severe and / or parents aren't available, call 911 immediately. Urgent Medications: _____ (include dosage)
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Additional Comments: _____

- I have instructed this student in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.
- In my professional opinion, this student should not carry his/her medication and it should be stored in the health office.

 Printed Name of Provider _____
Phone

 Provider Signature _____
Date