

STUDENT

First: _____

Last: _____

DOB: _____ Grade: _____

PARENT

Parent's Names: _____

Father Cell: _____

Mother Cell: _____

→ PARENT SIGNATURE: _____ DATE: _____

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

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 _____ Not required
 PRE-TREATMENT: _____ Before Recess (select treatment to the right)
 _____ Before P.E./Sports (select treatment to the right)

GIVE THE STUDENT: Medicine: _____
 How much: _____
 Where: _____

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

Peak flow from _____ to _____

MEDICINE	METHOD	HOW MUCH	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

Peak flow from _____ to _____

Call your doctor if: _____

MEDICINE	METHOD	HOW MUCH	HOW OFTEN
			times per day
			times per day

If yellow zone symptoms continue for 24 hours or if a child needs extra rescue medicine more than two times per week, call your child's doctor.

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

Peak flow from _____ to _____ OR peak flow less than _____

THIS IS AN EMERGENCY!

Continue green zone medicines and do the following:

☐ _____ puffs of Albuterol/Xopenex

☐ one vial of Albuterol/Xopenex

Inhaled every 20 minutes for a total of _____ doses.

CALL DOCTOR NOW! If you cannot reach doctor, **CALL 911**
or go directly to the **EMERGENCY ROOM! DO NOT WAIT!**

→ **IF CHECKED STUDENT WILL SELF-CARRY INHALER.**

This student is capable and has been instructed in the proper method of self-administering medications named above. All students are encouraged to provide an additional inhaler to the health room. Middle and upper school students are encouraged to self-carry their emergency medication.

→ PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME PRINTED: _____ PHONE: _____

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY MAY 27, 2022.
 THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.