Cough or cold symptoms
Wheezing
Tight chest or shortness of breath
Cough at night
Other: __________

Peak flow between               and               (50%-79% personal best)
Medication is not helping within 15-20 mins
Breathing is hard and fast
Nasal flaring or intercostal retraction
Lips or fingernails blue
Trouble walking or talking
Other: __________
Peak flow less than               (50% personal best)

Breathing is good
No cough or wheeze
Can work, exercise, play
Other: __________
Peak flow greater than               (80% personal best)

Prior to exercise/sports/physical education (PE)

Medication (Rescue Medication)

If symptoms do not improve in               minutes, notify the health care provider and parent/guardian.
If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.

Medication

If symptoms do not improve in               minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911

CHEK SYMPTOMS / INDICATIONS FOR MEDICATION USE

GREEN ZONE

CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED

EXERCISE ZONE

YELLOW ZONE

RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

RED ZONE

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911:

HEALTH CARE PROVIDER AUTHORIZATION
I authorize the administration of the medications as ordered above.
Student may self-carry medications □ Yes □ No
Health Care Provider Name: ____________________________
Signature: ____________________________ Date: __________

PARENT/GUARDIAN AUTHORIZATION
I authorize the administration of the medications as ordered above.
I acknowledge that my child □ is □ is not authorized to self-carry his/her medication(s):
Parent/Guardian Name: ____________________________
Signature: ____________________________ Date: __________

REVIEWED BY SCHOOL NURSE
Name: ____________________________
Signature: ____________________________ Date: __________
Authorized to self-carry medications: □ Yes □ No