

## GREEN ZONE

### GOOD!

#### Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities



#### What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: \_\_\_\_\_

- Avoid your triggers:

Tobacco smoke \_\_\_\_\_

- Notes: \_\_\_\_\_

**PEAK FLOW** \_\_\_\_\_ — \_\_\_\_\_

## YELLOW ZONE

### CAUTION!

#### Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)



#### What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)

- Notes: \_\_\_\_\_

- If not better in 24-48 hours, call your doctor or nurse!

- If at school, call parent

**PEAK FLOW** \_\_\_\_\_ — \_\_\_\_\_

## RED ZONE

### DANGER!

#### Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping



#### What You Should Do

- Get help now
- Take a nebulizer treatment **OR** Take 4 puffs of quick relief medicine now

**CALL YOUR DOCTOR OR NURSE NOW!**

**OR**

**Go to the Emergency Room or Call 911**

**PEAK FLOW** less than \_\_\_\_\_

**Classification:**

Intermittent

Mild Persistent

Moderate Persistent

Severe Persistent

**DAILY CONTROLLER MEDICINE**

**HOW MUCH**

**HOW OFTEN**

<input type="checkbox"/> Pulmicort Respules		_____ times/day
<input type="checkbox"/> Pulmicort Flexhaler		_____ puffs _____ times/day
<input type="checkbox"/> Flovent		_____ puffs _____ times/day
<input type="checkbox"/> Singulair		At bedtime
<input type="checkbox"/> Asmanex		_____ puffs At bedtime
<input type="checkbox"/> Symbicort	2 puffs	2 times/day
<input type="checkbox"/> Advair	_____ puffs	2 times/day
<input type="checkbox"/> Other _____		

**QUICK RELIEF MEDICINE**

<input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer
Med: _____
Dose: _____
Frequency: _____
<input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer
Med: _____
Dose: _____
Frequency: _____

Use Spacer



**REMINDER: GET A FLU SHOT**

School: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This child may carry his/her: Inhaled Asthma Medicine  Yes  No Epi-Pen  Yes  No  N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse:  Yes  No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature \_\_\_\_\_ Phone \_\_\_\_\_

School Nurse Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_ Phone \_\_\_\_\_