

(To Be Completed By Health Care Provider)

Name: _____ Date of Birth: _____ Grade: _____
 Home Address: _____ Home Phone: _____
 School/Daycare: _____ Emergency Contact/Phone: _____

Asthma Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent
Asthma Triggers: Colds Exercise Animals Dust Smoke Food Weather Other

1. Green Zone: Good Control



Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

Personal Best Peak Flow _____

Peak Flow 80 to 100 % of personal
best: _____ to _____

Medicine that will control your asthma -- Use Every Day

Daily Medicine	How much/When to take
_____	_____
_____	_____
_____	_____

15 minutes before sports use this medicine to prevent symptoms _____ 2 puffs with spacer

Yes No

Student may carry and use this medicine at school (Check Box)

Yes No

2. Yellow Zone: Be Careful



Child has any of these:

- Cough
- Wheeze
- Tight Chest
- Wakes up at night

Peak flow 50 to 80% of personal best:

_____ to _____

Take your Daily Medicine and add this Rescue Medicine when you have breathing problems

Rescue Medicine	How much /When to take
_____	2 puffs for cough or wheeze using a spacer

Give medicine again in 4 to 6 hours if child keeps having breathing problems. **CALL DOCTOR IF NOT BETTER**

**Call doctor if these medicines are used more than:
two times a week during the day
or
two times a month during the night.**

3. Red Zone: DANGER



Child has any of these:

- Need to repeat Rescue Medicine more than every 3-4 hours
- Struggling to breathe
- Can't walk or talk
- Lips are blue

Peak flow less than 50%: of
personal best: _____

Take These Medicines Right Away and Call Doctor

Rescue Medicine	How much/When to take
_____	2 puffs right away using a spacer



Call 911 if symptoms worsening or inhaler not helping after 15 minutes, can't walk or talk well, nostrils open wide, chest or neck pulled in or lips blue.

Give Rescue Medicine again while waiting for the ambulance

Health Care Provider Name: _____ Phone: _____ Fax: _____
Please Print

Health Care Provider Signature: _____ Date: _____

Patient/Parent Signature: _____ Date: _____

WHITE – PATIENT COPY

YELLOW – SCHOOL/DAY CARE COPY

PINK – PROVIDER COPY