

Last Name: _____ First Name: _____
Date of Birth (mm/dd/yyyy): _____ Medical Record #: _____
School Name: _____ School Contact Phone #: _____
Parent/Guardian Name: _____ Parent/Guardian Phone #: _____
Emergency Contact: _____ Emergency Phone #: _____
Health Care Provider Name: _____ Health Care Provider Phone #: _____

To be completed by health care provider: Asthma Severity: [] Mild Intermittent [] Mild Persistent [] Moderate Persistent [] Severe Persistent

Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.

Asthma symptoms are triggered by: [] Exercise [] Dust [] Animal dander [] Strong Odors or Fumes [] Mold [] _____

Green Zone

Personal Best Peak Flow (PF) _____ Date: _____

Peak flow is between _____ (80% of personal best) and _____ (100% of personal best)

1. Take CONTROLLER medication(s) (at home) EVERY DAY:

Take _____ inhaler _____ puffs _____ times/day.
Name of Medicine How much How often

Take _____ inhaler _____ puffs _____ times/day.
Name of Medicine How much How often

If asthma is triggered by exercise (at school or home), take [] Albuterol or _____ inhaler _____ puffs at least _____ minutes before exercise. Restrictions or activity limitations: _____

Yellow Zone-Caution! DO NOT LEAVE STUDENT ALONE!

Peak flow is between _____ (50% of personal best) and _____ (80% of personal best).

1. Begin QUICK RELIEF medication (at school or home) right NOW:

Take [] Albuterol or _____ inhaler _____ puffs OR _____ solution _____ ml by nebulizer.
Name of Medicine How much Name of Medicine How much

If symptoms are better or if the peak flow is improved within [] 15 minutes/ _____ minutes, THEN repeat QUICK RELIEF MEDICATION (as listed above in 1) every _____ hours for _____ days.
Number Number

If symptoms are NOT better or if the peak flow is NOT improved, go to Red Zone.

[] Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.

2. Attention Parent/Guardian (Home Instructions):

[] Call your child's Health Care Provider

[] Continue to take CONTROLLER medication (at home) everyday as written above in Green Zone instructions.

[] Increase CONTROLLER medication:

Take _____ inhaler _____ puffs _____ times/day for _____ days.
Name of Medicine How much How often Number

Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below _____ (50% of personal best).

1. Take QUICK RELIEF medication (at school or home) right NOW:

Take [] Albuterol or _____ inhaler _____ puffs OR _____ solution _____ ml
Name of Medicine How much Name of Medicine How much

by nebulizer and REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE!

• Call 9-1-1 immediately and call Parent/Guardian

2. Attention Parent/Guardian (Home Instructions):

[] Call your child's Health Care Provider. [] Continue CONTROLLER medication (at home):

Take _____ inhaler _____ puffs _____ times/day for _____ days.
Name of Medicine How much How often Number

[] And ADD _____ mg orally once daily for _____ days.
Name of Medicine How much Number

Authorization and Disclaimer from Parent/Guardian: My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications: Yes [] No []

Parent/Guardian Signature

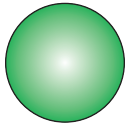
Date

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: Yes [] No [] (This authorization is for a maximum of one year from signature date.)

Healthcare Provider Signature

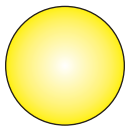
Date

Using Symptoms and/or Peak Flow to Know Your Zone



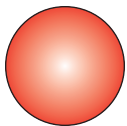
Green Zone

- ✓ No cough or wheeze at day or night.
 - ✓ No chest tightness.
- OR
- ✓ **Peak flow** is between _____ (80% of personal best) and _____ (100% of personal best).



Yellow Zone - Caution!

- Any asthma symptoms:
- ✓ Cough or wheeze at day or night.
 - ✓ Chest tightness.
 - ✓ Problems playing.
 - ✓ Waking at night with asthma symptoms.
- OR
- ✓ **Peak flow** is between _____ (50% of personal best) and _____ (80% of personal best).



Red Zone - Medical Alert!

- Any asthma symptoms:
- ✓ Persistent cough or wheeze.
 - ✓ Severe chest tightness.
 - ✓ Can not walk, talk, or move well.
 - ✓ Blue skin color around lips or nails.
- OR
- ✓ **Peak flow** is below _____ (50% of personal best).



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named child's medical record to and from:

School District to Which Disclosure is Made Address / City and State / Zip Code

Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following: All health information; or
 Disease-specific information as described:

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____
(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Printed Name Signature Date

Relationship to Patient/Student Area Code and Telephone Number