Pasco County Schools

Asthma Medical Management Plan

Student's Name: ___	Student ID: __	DOB: _____	School Year: __
School: _____		Grade: _____	Home Room: __
Parent/Guardian #1: _____	Home #: __	Cell #: __	Work #: __
Parent/Guardian #2: _____	Home #: __	Cell #: __	Work #: __
Parent/Guardian's E-mail Address: _____			
Healthcare Provider (s): _____		Phone: __	Fax: __

Green Zone: Go!	Take these CONTROL (PREVENTION) Medicines EVERY Day
You have **ALL** of these: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night **Peak flow:** _____ to _____ (More than 80% of Personal Best **Personal best peak flow**: _______________	**Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.** No control medicines required. Dulera ______ Symbicort ______ Advair ______ , ____ puff (s) ____ times a day **Combination medications: inhaled corticosteroid with long-acting -agonist** Alvesco _____ Asmanex ____ Azmacort _____ Flovent ____ Pulmicort QVAR ____ **Inhaled Corticosteroid or Inhaled corticosteroid/long-acting -agonist** ____ puff (s) MDI ___ times a day **Or** ____ nebulizer treatment (s) ___ times a day Singulair or __________________________, take ____ by mouth once daily at bedtime Leukotriene antagonist **For asthma with exercise, ADD:** Albuterol or ____________________, _____ puffs with spacer 15 minutes before exercise
Yellow Zone: Caution!	Continue CONTROL Medicines and ADD RESCUE Medicines
You have **ANY** of these: • First sign of a cold • Cough or mild wheeze • Tight chest • Shortness of breath • Can do some, but not all of usual activities. **Peak flow in this area:** _____ to _____ (50%-80% of Personal Best)	__________________ , ______ puff(s) MDI **with spacer** every ______ hours as needed Fast-acting inhaled β−agonist **OR** __________________ , ______ nebulizer treatment(s) every ______ hours as needed Fast- acting inhaled β−agonist **IF SYMPTOMS PERSIST MOVE TO RED ZONE – EMERGENCY!**
Red Zone: EMERGENCY!	Continue CONTROL & RESCUE Medicines and GET HELP!
You have **ANY** of these: • Can't talk, eat or walk well • Medicine is not helping • Breathing hard and fast • Blue lips and fingernails • Tired or lethargic • Ribs show **Peak flow in this area:** Less than ___________ (Less than 50% of Personal) Best)	____________________ , ____ puff(s) MDI with spacer **every _____ minutes,** for _______ treatments Fast-acting inhaled â−agonist **OR** ____________________ , ____ nebulizer treatment **every _____ minutes,** for _____ treatments Fast-acting inhaled â−agonist **Call 911 for an ambulance!**

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.

Parent/Guardian Signature: ______________________________ **Date:** ______________

Physician's/Mid-Level Practitioner's Signature: ______________________________ **Date:** ______________

School Health Registered Nurse Signature: ______________________________ **Date:** ______________