Patient name:	Date of birth:
Date Time	Height Weight
Asthma severity **Allergies:** **Food Allergies:** **Medication Allergies:**	**Other Triggers:**
Green Zone: I feel good • Can work and play • Can sleep at night • No cough or wheeze	**Take these controller medications every day:** Additional orders:
Peak flow range_____to_____ (80-100% of personal best/predicted)	**For physical activity/gym/recess, take:**
Yellow Zone: I do not feel good • Cold with cough • Wake up at night with cough • Wheeze, tight chest or trouble breathing Peak flow range_____to_____ (50-79% of personal best/predicted)	**Keep taking Green Zone <u>controller medicines</u>.** **Take these <u>reliever medications</u> to keep asthma from getting worse:** Additional orders:
If getting less than 4 hours of relief from albuterol, contact your health care provider.	
Red Zone: I feel awful • Breathing is hard and fast • Getting worse and medicine not helping • Cough continuously Peak flow range_____to_____ (Less than 50% of personal best/predicted)	**Keep taking the Green and Yellow Zone medicines.** **Take these medications NOW and call your health care provider:** Additional orders:
If breathing does not improve and you cannot contact your health care provider, go to the emergency room. **CALL 911 if:** • **You can't talk in full sentences** • **You can't get air** • **You are worried about getting through the next 30 minutes** • **Fingernails or lips are grey or blue**	
INFLUENZA SHOT IN THE FALL	**AVOID ASTHMA TRIGGERS** **NO SMOKING IN HOME OR CAR**
Follow-up appointment at: Clinic name, clinic and phone number	Return to clinic in:
Parent/guardian signature	Date
Health care provider signature	Date
Provider name	

AAP has been given and reviewed with patient and/or parent. This form provides consent for school/daycare to administer to my child the above medicine as provided by parent or guardian and allows the child to carry the inhaler for which our provider has assessed ability and if approved by the school nurse.