<table>
<thead>
<tr>
<th>Symptom/Indication</th>
<th>Medication Use</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing is good</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No cough or wheeze</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can work, exercise, play</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak flow greater than</td>
<td></td>
<td></td>
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</tbody>
</table>

**GREEN ZONE**

**Controller Medication** - Use Daily At Home Unless Otherwise Indicated

- Breathing is good
- No cough or wheeze
- Can work, exercise, play
- Other:
- Peak flow greater than (80% personal best)

**EXERCISE ZONE**

Prior to exercise/sports/physical education (PE)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rescue Medication)</td>
<td></td>
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</tr>
</tbody>
</table>

**YELLOW ZONE**

**Rescue Medications** - To Be Added to Green Zone Medications for Symptoms

- Cough or cold symptoms
- Wheezing
- Tight chest or shortness of breath
- Cough at night
- Other:
- Peak flow between ___ and ______ (50%-79% personal best)

**RED ZONE**

**Emergency Medications** - Take These Medications and Call 911

- Medication is not helping within 15-20 mins
- Breathing is hard and fast
- Nasal flaring or intercostal retraction
- Lips or fingernails blue
- Trouble walking or talking
- Other:
- Peak flow less than (50% personal best)

**Contact the Parent/Guardian After Calling 911**

**Health Care Provider Authorization**

I authorize the administration of the medications as ordered above.

Student may self-carry medications: [ ] Yes [ ] No

Health Care Provider Name: ____________________________

Signature: ____________________________ Date: ____________

**Parent/Guardian Authorization**

I authorize the administration of the medications as ordered above.

I acknowledge that my child [ ] is [ ] is not authorized to self-carry his/her medication(s):

Parent/Guardian's Name: ____________________________

Signature: ____________________________ Date: ____________

**Reviewed by School Nurse**

Name: ____________________________

Signature: ____________________________ Date: ____________

Authorized to self-carry medications: [ ] Yes [ ] No

10/2012