**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 E-Mail Address: |  |
| Healthcare Provider(s): |  | Phone #: |  | Fax #: |  |
|  |
| **Green Zone: Go!** | Take these CONTROL (PREVENTION) Medicines EVERY DAY |
|  | **Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.** |
|  |
| You have **ALL** of these: | [ ]  No control medicines required. |
| * Breathing is easy
 |  |
| * No cough or wheeze
 | [ ]  Dulera | [ ]  Symbicort | [ ]  Advair |  | Puff(s) |  | Times a day |
| * Can work and play
 | Combination medications inhaled corticosteroid with long-acting β-2-agonist |
| * Can sleep all night
 |  |
|  | [ ]  Alvesco | [ ]  Asmanex | [ ]  Azmacort | [ ]  Flovent | [ ]  Pulmicort | [ ]  QVAR |
| **Peak flow:** |  | to |  | Inhaled Corticosteroid or inhaled corticosteroid/long-acting β-2-agonist |
| (More than 80% of Personal Best) |  |
|  |  | Puff(s) MDI |  | times a day Or |  | nebulizer treatments(s) |  | times a day |
| **Personal best peak flow** |  | [ ]  Singulair or, |  | Take |  | By mouth once daily at bedtime Leukotriene antagnoist |
|  |  |
| **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
 | , |  | Puff(s) MDI **with spacer** every |  | hours as needed |
| * Cough or mild wheeze
 |  |
| * Tight chest
 | Fast-acting inhaled β-agonist |
| * Shortness of breath
 |  |
| * Can do some, but not all of usual activities.
 | **OR** |
|  |  |
| **Peak flow in this area:** | , |  | nebulizer treatment(s) every |  | hours as needed |
|  | to |  | Fast – acting inhaled β-agonist |
| (50% - 80% of Personal Best) |  |
|  | **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
 | , |  | Puff(s) MDI with spacer every |  | Minutes, for |  | treatments |
| * Breathing hard and fast
 | Fast-acting inhaled â-agonist |
| * Blue lips and fingernails
 |  |
| * Tired or lethargic
 | OR |
| * Ribs show
 |  |
|  | , |  | Nebulizer treatment every |  | Minutes, for |  | treatments |
| **Peak flow in this area:** | Fast-acting inhaled â-agonist |
| Less than: |  |  |
| (less than 50% of Personal Best) | **CALL 911 FOR AN AMBULANCE!** |
|  |
| **I hereby authorize the above-named physician and Pasco County School’s 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. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent’s Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district’s resources identifying my rights (including the notices located at** [**https://www.pasco.k12.fl.us/ssps/page/parent\_notices**](https://www.pasco.k12.fl.us/ssps/page/parent_notices)**, and pursuant the Parent’s Bill of Rights, Chap.1014, Fl. Stat.),** **and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.**  |
|  |  |  |  |
| **Parent/Guardian Signature:** |  | **Date:** |  |
|  |  |  |  |
| **Physician’s/Mid-Level Practitioner’s Signature:** |  | **Date:** |  |
|  |  |  |  |
| **School Health Registered Nurse Signature:** |  | **Date:** |  |

**Revised 5/2022**