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 E-Mail Address:			
Healthcare Provider(s):		Phone #:	Fax #:

GREEN ZONE: Go!

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 _____

Take these CONTROL (PREVENTION) Medicines EVERY DAY

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No Control medicines required.

☐ Dulera ☐ Symbicort ☐ Advair _____ Puffs _____ Times a day
Combination medications inhaled corticosteroid/long-acting β-2-agonist

☐ Alvesco ☐ Asmanex ☐ Azmacort ☐ Flovent ☐ Pulmicort ☐ QVAR
Inhaled Corticosteroid or inhaled corticosteroid/long-acting β-2-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!

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)

Continue CONTROL Medications and ADD RESCUE Medicines

_____ , _____ 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!

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)

Continue CONTROL & RESCUE Medications and **GET HELP!**

_____ , _____ 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 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(s). 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, 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