

WHAT TO DO WHEN YOU HAVE SYMPTOMS

GREEN ZONE

GOOD!

Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities



What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: _____

- Avoid your triggers:
Tobacco smoke

- Notes: _____

PEAK FLOW _____ — _____

YELLOW ZONE

CAUTION!

Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)



What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)

- Notes: _____

- If not better in 24-48 hours, call your doctor or nurse!

- If at school, call parent

PEAK FLOW _____ — _____

RED ZONE

DANGER!

Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping



What You Should Do

- Get help now
- Take a nebulizer treatment **OR** Take 4 puffs of quick relief medicine now

CALL YOUR DOCTOR OR NURSE NOW!

OR

Go to the Emergency Room or Call 911

PEAK FLOW less than _____

MEDICINES

Classification:

- ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

DAILY CONTROLLER MEDICINE	HOW MUCH	HOW OFTEN
<input type="checkbox"/> Pulmicort Respules		_____ times/day
<input type="checkbox"/> Pulmicort Flexhaler		_____ puffs _____ times/day
<input type="checkbox"/> Flovent		_____ puffs _____ times/day
<input type="checkbox"/> Singulair		At bedtime
<input type="checkbox"/> Asmanex		_____ puffs At bedtime
<input type="checkbox"/> Symbicort	2 puffs	2 times/day
<input type="checkbox"/> Advair	_____ puffs	2 times/day

☐ Other _____

QUICK RELIEF MEDICINE
<input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer
Med: _____
Dose: _____
Frequency: _____
<input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer
Med: _____
Dose: _____
Frequency: _____

☐ Use Spacer **REMINDER: GET A FLU SHOT**

SIGNATURES

School: Dirigo Elementary School **Phone:** 207-562-4207 **Fax:** 207-562-8775

This child may carry his/her: Inhaled Asthma Medicine ☐ Yes ☐ No Epi-Pen ☐ Yes ☐ No ☐ N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse: ☐ Yes ☐ No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature _____ **Phone** _____

School Nurse Signature _____

Parent Signature _____ **Phone** _____