







Patient Name: _____ MRN: _____ Date of Birth: _____
 Parent Name: _____ Phone: _____
 Clinic/PCP: _____ Phone: _____ Child's next appointment: _____
 School: _____ Phone: _____

GREEN I Feel Good	<ul style="list-style-type: none"> Breathing is good No cough or wheeze Can work and play  <p>Peak Flow Number _____ to _____ (80-100% of personal best)</p>	<p>PREVENT asthma symptoms every day: <i>(Rinse mouth after using inhalers)</i></p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>DHS Formulary Medicine:</u></th> <th style="text-align: left;"><u>How much:</u></th> <th style="text-align: left;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> QVAR® 40, 80mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Flovent® 44¹, 110¹, 220²mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> PULMICORT®³ 90, 180mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Advair®⁴ 100/50, 250/50mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Dulera®⁵ 100/5, 200/5mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Montelukast 4, 5, 10mg</td> <td>_____ Tablets</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Budesonide®⁶ 0.25, 0.5mg</td> <td>in nebulizer</td> <td>_____ times per day</td> </tr> </tbody> </table> <p>20 minutes before exercise, use this medicine: _____</p> <div style="border: 1px solid black; padding: 5px; font-size: small;"> ¹Restricted to children; ²Allergy use only; ³Restricted to pregnancy; ⁴Restricted to children <12; ⁵restricted to children ≥ 12; ⁶restricted to children <9 </div>	<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>	<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Montelukast 4, 5, 10mg	_____ Tablets	_____ times per day	<input type="checkbox"/> Budesonide® ⁶ 0.25, 0.5mg	in nebulizer	_____ times per day									
<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>																																	
<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Montelukast 4, 5, 10mg	_____ Tablets	_____ times per day																																	
<input type="checkbox"/> Budesonide® ⁶ 0.25, 0.5mg	in nebulizer	_____ times per day																																	
YELLOW I Do NOT Feel Good	<ul style="list-style-type: none"> Cough or wheeze Difficulty breathing Wake up at night <div style="display: flex; justify-content: space-around;">   </div> <div style="display: flex; justify-content: space-around;">   </div> <p>Peak Flow Number _____ to _____ (50-80% of personal best)</p>	<p>SLOW DOWN & take relief medicine: <i>(Rinse mouth after using inhalers)</i></p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>DHS Formulary Medicine:</u></th> <th style="text-align: left;"><u>How much:</u></th> <th style="text-align: left;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Albuterol/*levalbuterol</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Albuterol/*levalbuterol</td> <td>in nebulizer</td> <td>_____ times per day</td> </tr> </tbody> </table> <p style="text-align: center;">(*only if on Managed Care formulary)</p> <div style="background-color: #e0e0e0; padding: 5px;"> <p>ALSO CONTINUE/INCREASE your preventive medicine:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>DHS Formulary Medicine:</u></th> <th style="text-align: left;"><u>How much:</u></th> <th style="text-align: left;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> QVAR® 40, 80mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Flovent® 44¹, 110¹, 220²mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> PULMICORT®³ 90, 180mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Advair®⁴ 100/50, 250/50mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Dulera®⁵ 100/5, 200/5mcg</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Montelukast® 4, 5, 10mg</td> <td>_____ Tablets</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Budesonide®⁶ 0.25, 0.5mg</td> <td>in nebulizer</td> <td>_____ times per day</td> </tr> </tbody> </table> </div>	<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>	<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day	<input type="checkbox"/> Albuterol/*levalbuterol	in nebulizer	_____ times per day	<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>	<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day	<input type="checkbox"/> Montelukast® 4, 5, 10mg	_____ Tablets	_____ times per day	<input type="checkbox"/> Budesonide® ⁶ 0.25, 0.5mg	in nebulizer	_____ times per day
<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>																																	
<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Albuterol/*levalbuterol	in nebulizer	_____ times per day																																	
<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>																																	
<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Montelukast® 4, 5, 10mg	_____ Tablets	_____ times per day																																	
<input type="checkbox"/> Budesonide® ⁶ 0.25, 0.5mg	in nebulizer	_____ times per day																																	
RED I Feel Awful	<ul style="list-style-type: none"> Medicine not helping Breathing hard, fast Can't talk/walk well  <div style="border: 1px solid black; padding: 10px; margin: 10px; text-align: center;"> <p>Repeat albuterol/levalbuterol in 20 minutes if needed x 3</p> </div> <p>Peak Flow Number _____ to _____ (<50% of personal best)</p>	<p>MEDICAL ALERT – GET HELP NOW! Call your doctor at _____</p> <p>Take these medicines until you talk to the doctor or for school, until you talk to the parent:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>DHS Formulary Medicine:</u></th> <th style="text-align: left;"><u>How much:</u></th> <th style="text-align: left;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Albuterol/*levalbuterol</td> <td>_____ Puffs</td> <td>_____ times per day</td> </tr> <tr> <td><input type="checkbox"/> Albuterol/*levalbuterol</td> <td>in nebulizer</td> <td>_____ times per day</td> </tr> </tbody> </table> <p style="text-align: center;">(*only if on Managed Care formulary)</p> <p><input type="checkbox"/> Prednisone (1-2mg/kg/day) _____ Tablets as follows: _____</p> <p><input type="checkbox"/> Prednisolone 15mg/5cc; 5mg/5cc _____ Teaspoons as follows: _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Continue to use all medications in the yellow zone - shaded box</p> </div> <div style="border: 2px solid black; padding: 5px; margin-top: 10px; text-align: center;"> <p>Don't wait – Call 911 if your asthma is severe or if no improvement after medicine</p> </div>	<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>	<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day	<input type="checkbox"/> Albuterol/*levalbuterol	in nebulizer	_____ times per day																								
<u>DHS Formulary Medicine:</u>	<u>How much:</u>	<u>When:</u>																																	
<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day																																	
<input type="checkbox"/> Albuterol/*levalbuterol	in nebulizer	_____ times per day																																	

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. ☐ Yes ☐ No

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications.

Print Parent/Guardian Name: _____ Signature: _____ Date: _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: ☐ Yes ☐ No
 (This authorization is for a maximum of one year from signature date)

Print Provider Name/Credentials: _____ Signature: _____ Date: _____

