

ASTHMA PEAK FLOW PLAN

Student: _____ Birth Date: _____
School: _____ School Nurse: _____
Phone Hm: _____ Parent Wk: _____ Cell: _____
Physician: _____ Physician Phone: _____
Other Contacts: _____ Phone: _____
Address: _____

Date: _____

PEAK FLOW ASSESSMENT: PERSONAL BEST PEAK FLOW LEVEL:

Green Zone : GO PEAK FLOW READING: to

1. No symptoms of an asthma exacerbation (no coughing, wheezing, shortness of breath).
2. Able to participate in usual activities.
3. Peak flow is at least 80% of personal best.
4. Student medications should include
5. Student should premedicate for activity. yes no
- 6.

Yellow Zone: CAUTION PEAK FLOW READING: to

1. Increased asthma symptoms including coughing, wheezing, shortness of breath, increased working at breathing, retractions, student may be coughing at night causing increased tiredness.
2. Usual activity somewhat limited, unable to run, play, school attendance may be impacted.
3. Increased need for medication including green zone medication plus
4. Peak flow is 50-80% of personal best.
5. Student should premedicate if ordered and self pace or decrease activity.
- 6.

Red Zone: DANGER PEAK FLOW READING: LESS THAN

RESPONSE: Medicate as ordered immediately and call parent or 911 if peak flow reading does not move into Yellow Zone 15-20 minutes after medication. Call 911 immediately for severe symptoms or if symptoms worsen in period after medication administration. See emergency care plan.

1. Very short of breath, coughing and wheezing that won't stop.
2. Usual activities severely limited, can't walk run play. Difficulty sleeping or sleeping upright
3. Can't talk in complete sentences, obvious difficulty breathing
4. Asthma symptoms have not gone away or return quickly despite medication.
5. Peak flow is less than 50% of personal best.
- 6.

Notify parent for:

- peak flow reading less than _____ .
- use of nebulizer at school.
- use of medication at school outside of normal routine.
- use of more than one dose of medication at school.
- at office discretion

Parent signature: _____ Date: _____

Physician signature _____ Date: _____