HOME MANAGEMENT PLAN OF CARE

Name: __________________________

GREEN ZONE: Doing well

Expected Peak Flow (Source: Nelson’s Pediatrics or Harriet Lane) = __________

YELLOW ZONE: Getting Worse

Contact your health care provider if you are using Quick-Relief Medication(s) >2 times per week, waking at night with difficulty breathing >2 times per month, or refilling your Quick-Relief Medication(s) >2 times per year.

RED ZONE: Medical Alert

Go to nearest hospital or call 911 or local emergency number __________________________ for ambulance.

FOR SCHOOL NURSE: This child is capable of carrying and administering the above Quick-Relief Medications** for his or her asthma. ___ YES ___ NO (Texas Inhaler Law)

MD Signature

My child has my permission to self-administer the above Quick-Relief Medications** at school.