

ST. VRAIN VALLEY SCHOOL DISTRICT  
STUDENT SERVICES

**PEAK FLOW METER INDIVIDUALIZED HEALTH PLAN**

**Student Name:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

My child, \_\_\_\_\_ requires the regular use of a peak flow meter at school. The following general plan of care should be followed to incorporate the use of the peak flow meter.

**Green Zone** peak flow meter readings: \_\_\_\_\_

When results within this range are attained, the following steps should be undertaken:

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**Yellow Zone** peak flow meter readings: \_\_\_\_\_

When results within this range are attained, the following steps should be undertaken:

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**Red Zone** peak flow meter readings: \_\_\_\_\_

When results within this range are attained, the following steps should be undertaken?

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Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

District Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_