Desoto County Schools

Dear Parents,

If your child has asthma and has an inhaler, please be sure to fill out an asthma medication permission form and have your doctor sign it. These forms are available at your school. According to Mississippi Senate Bill 2393, students are allowed to self-administer asthma medications at school with written consent from the parent and health care provider. The asthma medication permission form has all required information on it. It has to be filled out **completely** and signed by your doctor.

It is also a requirement of the bill for each student with asthma to have an asthma action plan on file with the school. The asthma action plan should be completed and signed by the physician each school year. These forms are also available at your school or we will accept one form your physician's office. An asthma action plan tells staff what to do in case your child has an asthma attack. These plans are copied and given to each teacher that has contact with your child during the school day. If your child participates in after school activities, please be sure their leaders receive a copy of the asthma action plan also.

It is very important to send an inhaler to school if your child has a history of asthma, even if they have not needed it very often. We want to be able to provide the appropriate care for your child in case of an emergency.

If you have any questions or concerns, please feel free to contact your school nurse or one of the nurses at the district office, 429-5271.

Thank You,

Desoto County School Nurses

Asthma Action Plan for Desoto County Schools

Student Information:
Name of Student: _____ DOB: _____
Grade: _____ Homeroom Teacher or Class: _____
Physical Education Days and Times: _____

Emergency Information:
Parent(‘s) or Guardian(‘s) names:_____
Mother: Telephone (W): _____ (H) _____
Telephone (cell) _____
Father: Telephone (W): _____(H) _____
Telephone (cell): _____
Other: Name: _____ Telephone: _____
Name: _____ Telephone: _____

In case of emergency, contact:
1st _____
2nd _____
3rd _____

Asthma Emergency Action:
The following are possible signs of an asthma emergency:

- *difficulty breathing, walking, or talking*
- *blue or gray discoloration of the lips or fingernails*
- *failure of medication to reduce worsening symptoms*

These signs indicate the need for emergency medical care. The steps that should be taken are:

- *activate the emergency system in your area (911)*
- *call parent/guardian or physician*

Triggers: _____

(Be sure to complete page 2)

Asthma Action Plan (continued)

All current Medications:

1. Medication _____ Dose _____ Time _____
2. Medication _____ Dose _____ Time _____
3. Medication _____ Dose _____ Time _____
4. Medication _____ Dose _____ Time _____

Medications to be given at school (if any)

1. Medication _____ Dose _____ Time _____
2. Medication _____ Dose _____ Time _____
3. Medication _____ Dose _____ Time _____

This section has to be completed by a physician:

Steps for an Acute Asthma Episode:

1. _____

2. _____

3. _____

4. _____

Personal best peak flow _____

Physician Signature: _____

(required)

*Physician Name: (printed)*_____

*Physician Telephone*_____

Parent/Guardian Signature: _____ *Date:* _____

Desoto County Schools
Permission Form For Prescribed Asthma Medication

Student: _____ Date of Birth: _____

School: _____ Grade: ____ Teacher: _____

This Portion To Be Filled Out By Physician
(or attach a copy of the prescription label)

Name of Medication: _____
Prescribed Dose: _____
Time of day for dosage: _____
Possible side effects of medicine: _____
This student is both capable and responsible for self-administering this medication.
_____NO _____ YES

This student has asthma and has been instructed in self-administration of asthma medications. _____NO _____ YES

This student may carry this medication. _____NO _____YES

Physician Signature (required): _____

Printed Physician name: _____
Physician address: _____
_____
Physician phone number: _____

This Portion To Be Filled Out By Parent/Guardian

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy.

Signing this form shall release the Desoto County School District and staff members from any liability of any nature that may result from the administration of medication to the student.

Parent/Guardian signature: _____ Date: _____

Telephone numbers: _____home _____ work