



# DESOTO COUNTY SCHOOLS

5 East South Street • Hernando, Mississippi 38632  
662-429-5271 • fax 662-429-4198 • Website: [www.desotocountyschools.org](http://www.desotocountyschools.org)

*"EXCELLENCE IS A COMMITMENT"*

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Dear Parents,

If your child has asthma, diagnosed by a Licensed Healthcare Provider, please complete and have your Healthcare Provider complete and sign an Asthma Medication and Action Plan Form. This form has to be filled out completely, signed, and stamped by your licensed healthcare provider. This form is available online at [www.desotocountyschools.org](http://www.desotocountyschools.org) and at your school. According to Mississippi Senate Bill 2218, the "Mississippi Asthma and Anaphylaxis Child Safety Act", students are allowed to self-administer asthma medications at school with written consent from the parent and healthcare provider.

Once we receive the Asthma Medication and Action Plan Form, copies will be made and distributed to each teacher that has contact with your child during the day. We do this in order to ensure a safe school environment for your child. It is also **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

## Desoto County Schools

### Asthma Medication and Asthma Action Plan Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

#### This Portion to be Completed by a Licensed Health Care Provider

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Times to be given: \_\_\_\_\_

Possible Side effects: \_\_\_\_\_

This student is capable of carrying and self-administering this medication: \_\_\_\_ Yes \_\_\_\_ No **If No, explain:** \_\_\_\_\_

Asthma triggers: \_\_\_\_\_

#### **Steps to Follow for an Acute Asthma Episode:**

1. \_\_\_\_\_

2. \_\_\_\_\_

**\*\*Call 911 if the inhaler does not seem to be helping, breathing continues to be difficult, nostrils are open wide (flared), or can't walk or talk well**

Licensed Health Care Provider Signature (Required): \_\_\_\_\_

Licensed Health Care Provider telephone Number: \_\_\_\_\_

Office Stamp (Required):

#### This Portion to be Completed by Parent/Guardian

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

If a student uses his/her medication in a manner other than prescribed, he/she may be subject to disciplinary action. The disciplinary action will not limit or restrict the student's immediate access to the medication.(Board Policy JGCDA)

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

Emergency contact if you cannot be reached: Name \_\_\_\_\_  
Number \_\_\_\_\_