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 _______

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**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