

# 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 \_\_\_\_\_