Migraine Action Plan

Student Name: _____School:_____

Date of Birth: _____Grade/Teacher_____

Emergency Contacts

Name	Relationship	Contact Number

Signs of Migraine

- Aura (describe)_____
- Headache which worsens with movement
- Nausea or vomiting
- Sensitivity to light, smell and noise
- Vision changes

Treatment Plan

- Student will notify teacher immediately.
- Student may take medication immediately. Send to office.
- Student may drink water immediately.
- Call Parent if medication is used for migraine or if no improvement within 15-30 minutes.

Medication

Name	Dosage	Route/Frequency	Comments

☐ **Self-carry. Student demonstrates competence.** I hereby request that my student carry and self-administer his/her medication. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carry such medication.

I give permission for this plan to be available for use in my child's school, and for the nurse to contact the below named physician by phone, fax or in writing if necessary to complete this plan. The Migraine Care Plan is required to be filled out by the physician each school year and /or whenever the health status or medications change. It is the responsibility of the parent to notify the School Nurse of these changes.

Parent/Guardian: _____Signature:_____Date:_____

Student's Name: _____Signature: _____ Date: _____

Physician's Name: _____Signature: _____ Date: _____