School Headache/Migraine Plan **School Year**_______

Name_____________________________ Grade/room_________
Parent/guardian____
Home phone_____________ Work phone___________ Cell phone___________
Other contact________________________________Phone_________________
Physician__________________ Hospital preference___________

Type of headache (migraine, cluster, tension, unknown):____

Triggers for headache:
Foods____
Activities____
Medications____
Stress____
Smells____
Lack of sleep____
Has emergency treatment been needed in the past year for pain?_______

Indicate the signs that are usually present during a headache/migraine

Moderate to severe pain__________Throbbing pain_______

Light sensitivity___________Sound sensitivity__________

Disabling pain____________Nausea and/or vomiting____________

Medications

Daily

Name________________Dose____________Time_________

Name________________Dose____________Time_________

Emergency Medication

Name____________________Dose__________supply should be sent to school. Call school nurse for forms.

Steps to take for a headache/migraine

1. Give medication as prescribed and rest for 30- 40 minutes in health room, return to class if able, if no resolution call parent.
2. If no medication available, rest and ice, return to class if able or call parent
3. Notify parent if:

Headache does not respond to treatment within 2 hours

Headaches have a sudden change in characteristic or features

Headaches are increasing in frequency

Parent to take student for follow-up care.

If you want additional help or have other concerns, please list:

____

____

Parent signature__________________________Date_________