Migraine Action Plan for school year ____________

Name: ____ DOB:________________

School: ____ Grade: ______________

Emergency Contact: _________________________________ Phone: ______________

List Triggers: ____

Aura (if any): ____

Signs of a Migraine Headache

- ☐ Severe Headache
- ☐ Nausea
- ☐ Vomiting
- ☐ Dizziness
- ☐ Sensitivity to light
- ☐ Sensitivity to noise

What to do if a migraine occurs

- ☐ Contact parent prior to medicating
- ☐ Give meds at onset of pain
- ☐ Student should return to class after taking medication
- ☐ Rest in dark, quiet place up to 30 min
- ☐ Student can return to class when pain level is _______ (1 to 10)
- ☐ Other: _______________________

Rescue Medication Orders

1. Take _____________________________ Dose___________Route_______May repeat after ________hours
2. Take _____________________________Dose___________Route________May repeat after ________hours
3. Take _____________________________Dose___________Route________May repeat after _______ hours

Provider or Parent Comments:

____

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I give permission for school personnel to administer the above listed medications as ordered to my student for the duration of the current school year. I give permission to share this information with staff on a need to know basis. This Migraine Action Plan is required to be completed by a physician each school year and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Parent/Guardian Signature: ____ Date: _____________

Healthcare Provider Signature: ____ Date: _____________

Provider address/phone number: ____