Veribest Independent School District Health Services

MIGRAINE ACTION PLAN

Effective date: _____

THIS STUDENT IS BEING TREATED FOR A MIGRAINE. THE INFORMATION BELOW SHOULD ASSIST YOU IF A MIGRAINE OCCURS DURING SCHOOL HOURS.

Student'sName:_____ Date of Birth:_____

Parent/Guardian: _____ Phone:_____ Cell:_____

Emergency Contact: _____ **Relationship**:_____ **Phone**:_____

Treating Physician: _____ Phone:_____

Significant medical history/diagnosis: _____

MIGRAINE INFORMATION:

Triggers/Warning signs: _____

Characteristics: _____

Frequency of occurrence: _____

Student's reaction: _____

TREATMENT PROTOCOL DURING SCHOOL HOURS:

List medications to be taken at school at the onset of migraine:

MEDICATION NAME	DOSE	DIRECTIONS

- Student will be allowed to rest in nurse's office for 15-20 minutes to allow medication(s) to begin taking effect.
- Student will be assessed for relief/worsening of symptoms.
- After this time, the student may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

NOTIFY THE PARENT IF:

- Headache is unresponsive to above treatment after _____hour(s)
- Headaches have a sudden change in characteristic or features.
- Headaches seem to be increasing in frequency
- Student should be referred to his/her physician after _____ occurrences within _____ week(s)/month

List additional steps to be taken in place of or in addition to medication:

_____

_____

_____

_____

_____

_____

Ideally, by treating symptoms early with the steps listed above, it is our combined effort to achieve the goal to keep the student in school and able to concentrate/participate in school activities and ultimately missing less school.

_____ _____

Physician signature Date Parent signature Date

Veribest ISD Medication Request & Administration Form

Dear Parent or Guardian:

To comply with Texas State Law, the following restrictions apply to the taking of medication by students while at school:

1. All medicine is to be brought to and kept in the school nurse's office.
2. Prescription and non-prescription medicine must be in the original container. Prescription medicine must be in a container with the pharmacy label for that student.
3. If prescription or non-prescription medicine must be given during the school day, it must be accompanied by a note signed by a parent or guardian giving authorized school personnel directions for its administration (time and dosage).
4. School personnel will not give any medicine, including Tylenol, unless it is provided by you, in the appropriate manner as stated above.

These restrictions are necessary for protection of the health and safety of your child. We will appreciate your cooperation in this matter.

Sincerely yours,

_____ 1055-2851

School Nurse Phone Number

I request that my child, _____, be given the following medication at school. I agree to comply with school policy regarding the administration of medication and understand that school personnel have the right to refuse to give medication at school if the medication policy is not followed.

Use this form only if you will be sending medication to be kept at school. **Veribest ISD personnel do not keep medications on hand to be given to students. Medication must be sent from home in the original container according to medication policy.**

Name of medication: _____
Dose to be given: _____
To be given DAILY or "AS NEEDED" (circle one)
Time for medication to be given: _____
How often "AS NEEDED" medication can be given: _____
_____
Reason for medication: _____
How long medication should be continued: _____
Other instructions: _____
Allergies: _____ Grade: _____

Parent Signature: _____
Phone Number: _____ Date: _____