MIGRAINE HEALTH CARE PLAN
RANDOLPH HIGH SCHOOL
SCHOOL YEAR ______________

Student Information:

Name: ______________________________ **Grade:** ______________

Date of Birth: ______________________

Emergency Contact Information:

Parent/Guardian Names: ____________________ ____________________
Cell Phone Numbers: ____________________ ____________________
Work Phone Numbers: ____________________ ____________________
Physician's Name: ____________________ **Phone #:**____________________
Other Emergency Contact #1: ____________________ **Phone #:** ____________________
Other Emergency Contact #2: ____________________ **Phone #:**____________________

Medical History: Migraine Headaches
Problem: Potential for pain and symptoms associated with migraine headaches
Goal: Relieve discomfort and minimize symptoms

Action Plan
(To Be Completed By Physician)

1. All staff interacting with the student should be aware of the following known triggers:
   ____

2. All staff interacting with the student should be aware of the following symptoms associated with a migraine that this student may experience:
   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________
   e. ______________________________

3. If the student reports any of the above symptoms, the student should be sent to the nurse's office for the following treatment:
   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________
   e. ______________________________

Migraine Health Care Plan

Medications to Be Administered in School

(Parents and Physician need to complete the attached Medication Authorization Form)

Name of Medication	Dosage	Frequency	Comments

Δ I give permission for this plan to be shared with my student's teachers, school staff and the Transportation Department, and for the school nurse to contact the above named physician by phone, fax, or in writing if necessary to complete this plan. _________ Parent Initials

The Migraine Health Care Plan is required to be filled out by a physician each school year and/or whenever the health status for medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Parent/Guardian:

Name ________________________ **Signature** _____________________________ **Date** ______________

Physician:

Name ________________________ **Signature** _____________________________ **Date**______________

Physician Stamp:

School Nurse:

Name ________________________ **Signature** _____________________________ **Date** ______________

RANDOLPH TOWNSHIP SCHOOLS
RANDOLPH, NEW JERSEY

Parent Authorization for Medication to be Taken During School Hours

Student's Name ______________________________ Sex _______ Date of Birth ______________

School ________________ Teacher ____________________ Grade ______ Room ______

Physician's Name   Address   Telephone

____

____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

____ ___________________________
Parent/Guardian Signature   Date

_______________________________________ ________________ __________________
Parent/Guardian's Name (please print)   Home Phone   Emergency Phone

Physician Authorization for Medications to be Taken During School Hours

TYPE OF ILLNESS: ____

MEDICATION/DOSAGE: ____

TIMES TO BE ADMINISTERED: ____

If medication is "when needed", describe indications:

____

____

HOW SOON CAN DOSAGE BE REPEATED? ____

POSSIBLE SIDE EFFECTS: ____

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: ___________________________________

____ ___________________________
Physician's Signature   Date

____
Physician's Name (please print)