Novi Community School District
Migraine Management Plan

Insert Photo with authorization from parent/ guardian only.

Student Name: _____ School Year: _____

School Attending: _____ Grade: _____

Teacher: _____

Reviewed by: _____ on _____
(Healthcare Provider Signature) Date

Acknowledged by: _____ Cell #1: _____
(Parent/Guardian Signature) Cell #2: _____

Acknowledged by: _____ on _____
(District Nurse Signature) Date

The above student has been diagnosed with migraine headaches. Migraines in this child are often identified by the following characteristics and could be triggered by:

Characteristics (Check those that apply):
- ☐ Auras/visual disturbances
- ☐ Nausea/vomiting
- ☐ Throbbing pain
- ☐ Dizziness
- ☐ Sensitivity to light/loud sounds
- ☐ Numbness or tingling of extremities
- ☐ Other: _____

Triggers:
- ☐ Hunger
- ☐ Inadequate hydration
- ☐ Lack of sleep
- ☐ Stress
- ☐ Hormonal changes
- ☐ Certain foods
- ☐ Bright lights/computer lights/loud noises
- ☐ Other: _____

Are medications needed to treat migraines? ☐ **No** ☐ **Yes**

This child has been prescribed: Give medication(s) at onset of migraine, without delay

	Medication	**Dose/Route**
#1		
#2		
#3		

☐ Child authorized to carry medication

Management of Migraines:
1. Avoid known triggers
2. Rest/ dim the lights/quiet music
3. Deep breathing/ relaxation techniques
4. Cold pack/compress to forehead
5. Medications as provided by parents
6. Other: _____

If needed, please allow the child to rest for_____. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

Please notify the parent if:

- Headache does not respond to given treatment
- Headaches have a sudden change in characteristics or features
- Vomiting occurs

CALL 911 IF: The child loses consciousness or has stroke-like symptoms including;

- Drooping or numbness on one side of the face versus the other. (Ask the person to smile to make the droop more apparent.)
- One arm being weaker or more numb than the other. Ask the individual to raise both arms up and hold them for a count of ten. If one arm falls or begins to drop, then this could be a sign of a stroke.
- Stability, which refers to steadiness on your feet. Sometimes individuals will fall, feel very dizzy or be unable to stand without assistance. Difficulty maintaining balance, trouble walking and loss of coordination are all possible stroke symptoms.
- Changes in speech including slurring, garbled, nonsensical words, or the inability to respond appropriately. Individuals experiencing a stroke may be difficult to understand, or they may have difficulty understanding others. Ask the person to repeat a simple sentence like "The sky is blue."

PARENT/GUARDIAN:

I request and give permission for (name of student) _____, to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name, must be current and be approved by student's physician.

_____ _____

Parent/Guardian signature **Date**

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of the student's counselor or building principal.