Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID 83854
PO Box 40, Post Falls, ID 83877
(208) 773-6976

Headache/Migraine Information

Dear Parent/Guardian:

If your child has headaches or migraines please complete this form and return it to your child's school.

Student's Name: ____
School: _______________________________ Grade: ____________ Teacher: ____________________________________
Parent/Guardian: ____Phone: _____________________
Physician's Name: ____ Phone: _____________________

1. Is your child being seen by a physician for headaches/migraines? ____

2. How often does your child suffer from headaches? ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Other: ____________

3. Indicate type of headache: ☐ Cluster ☐ Tension ☐ Migraine ☐ Sinus ☐ Unknown ☐ Other: _________________

4. What possibly triggers your child's headaches? ☐ Stress ☐ Allergies ☐ Recent Illness ☐ Recent injury
☐ Medications ☐ Eye Strain (has your child had an eye exam in the last year? Y/N ☐ Other: ____________________

5. What symptoms does your child exhibit? ☐ Pain on forehead ☐ Pain in temples ☐ Pain behind eyes
☐ Pain in back of head/neck ☐Nausea/vomiting ☐ Light sensitivity ☐ Noise sensitivity

6. What has decreased the pain for your child in the past? ☐ Applying cold packs to head/neck ☐ Eating
☐ Caffeinated beverage ☐ Medication ☐ Rest ☐ Other: _____________________________________

7. Does your child take medication for Headaches/Migraines? ☐ Yes ☐ No ☐ Not currently

Please list all medications prescribed, supplements or over the counter:

Medications	**Dose/Time**	**Side Effects**

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

*An **Authorization for Medication Administration** form will need to be completed.*

8. If the school nurse has more questions regarding this form what is your preferred method of contact?
☐Phone or ☐ Email: ____

Parent/Guardian's signature: ____ Date: _______________

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

Revised: June 2020