Carroll County Public Schools
Parent Health Questionnaire – Headaches/Migraines

Student Name: _____ Date: _____
Date of Birth: _____ Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has Migraines and/or Headaches. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. What symptoms and/or auras does your child have with a headache/migraine?:

_____

_____

2. Please list specific triggers for your child's headaches/migraines?

_____

_____

3. Will medication be kept at school? If yes, please list: _____
4. Does your child take medication at home for headaches/migraines? If yes, please list: _____

_____
5. Date of your child's last migraine: _____
6. Has your child ever been hospitalized for a migraine? Yes / No Date of hospitalization: _____
7. Is your child under the care of a Health Care Provider for this condition? Yes / No
   Health Care Provider Name:_____Phone Number: _____
8. How do you manage the headaches/migraines at home?

_____

_____

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

Parent/Guardian Signature:_____ Date: _____

Received by School Nurse:
Nurse Signature: _____ Review Date: _____

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