Carroll ISD Health Services
Parental Authorization for Migraine Action Plan

Parent please answer:
Special Ed services? yes / no
Active 504 plan? yes / no
I would like 504 information yes / no

Name:____ D.O.B.:______________ Grade/Teacher:________________________
Parent/Guardian: ______________________________________ Phone: _____________________________
Parent/Guardian: ______________________________________ Phone: _____________________________
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # __________
Before/After school activities: ☐ Athletics ☐ Band ☐ Club: ________________ ☐ Tutoring ☐ Other______________________

Diagnosis/Significant medical history:____
____
Allergies:____

Non-Pharmacological treatments:
Frequency, severity, and duration of attacks:
Presenting or typical signs and symptoms:
Triggers/ precipitating factors:
Restrictions:
Additional assessment information:
Can student identify signs and symptoms of an impending migraine? ◯yes ◯no ◯sometimes
Can student appropriately select treatment based on severity of migraine? ◯yes ◯no ◯sometimes
Current **Medications** to migraines/ headaches:____ ____Keep in Clinic? ◯ yes ◯ no
Does student have nutrition and/ or fluid management needs? Please describe:

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.

Physician- Print Name:	Physician Phone:
Parent/ Guardian Signature:	Parent/ Guardian Phone: