

# Cannon School Migraine Action Plan

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant medical history/diagnosis: \_\_\_\_\_

## **MIGRAINE INFORMATION:**

Triggers/Warning signs: \_\_\_\_\_

Characteristics: \_\_\_\_\_

Frequency of occurrence: \_\_\_\_\_

Student's reaction: \_\_\_\_\_

## **TREATMENT PROTOCOL DURING SCHOOL HOURS:**

List medications to be taken at school at the onset of migraine:

MEDICATION NAME	DOSE	DIRECTIONS

## **Protocol following medication administration:**

The student will be allowed to rest in the nurse's office for 20 minutes to allow the medication(s) to take effect.

The student will then be assessed for relief/worsening of symptoms.

After this time, the student may return to the classroom if adequate pain relief is achieved to continue with the school day. If adequate pain relief is not achieved after 20 minutes, please list the next steps to be taken by the school nurse:

\_\_\_\_\_

## **NOTIFY THE PARENT IF:**

Headache is unresponsive to above treatment after \_\_\_\_\_ minutes.

Headaches have a sudden change in characteristics or features.

Headaches seem to be increasing in frequency

Student should be referred to his/her physician after \_\_\_\_\_ occurrences within \_\_\_\_\_ week(s)/month

**List additional steps to be taken in place of or in addition to medication:**

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**At what point should the student not be permitted to drive home without parental consent? After what medication?** \_\_\_\_\_

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\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Date