Student Services

Health Care Action Plan—Migraines

Please return form to: _____ School _____ Fax

Name:_____ DOB:_____

ID#:_____ Grade:_____ Parent/Guardian:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone: (mother)_____ (father)_____

Emergency Contact:_____ Phone:_____

Primary Care Provider:_____ Phone:_____

Specialist:_____ Phone:_____

Symptoms and History of Migraines (including age of onset, aura or prodromal symptoms, if nausea or vomiting occurs, visual changes, etc.)

Medications available at school for treatment

Interventions:

1. Allow to rest, preferably in a quiet, darkened room for 20 minutes after taking medication, if needed.
2. If medication isn't taken soon enough and symptoms aren't relieved, notify parents.

Restrictions/Precautions

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

School Nurse	Date	Parent/Guardian	Date	Health Care Provider	Date