BENCHMARK CAMP

Migraine Action Plan

Student Name:_____

Date Of Birth:_____ Grade/Teacher:_____

Physician's Name:_____Phone:_____

EMERGENCY CONTACTS	NAME	HOME #	WORK #	CELL #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Signs of a Migraine Headache

- Severe headache
- Nausea
- Dizziness
- Vomiting
- Sensitivity to light, smell and noise

The severity of symptoms can quickly change. All of the above symptoms can potentially occur.

Administer medication at onset of severe headache.
Keep child quiet and comfortable.
Call parent/guardian or emergency contact if no improvement within 15-30 minutes.
Other instruction for this child:_____

Medication

Name	Dosage	Time	Comments

☐ I give permission for this plan to be available for use in my child's school, and for the nurse to contact the above named physician by phone, fax, or in writing if necessary to complete this plan.

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The Migraine care plan is required to be filled out by a physician **each school year** and/or **whenever the health status or medications change** and it is the responsibility of the parent to notify the school nurse of these changes.

Parent/Guardian: Name_____Signature:_____Date:

Physician's Name:_____ Signature:_____Date:

School Nurse Name:_____Signature:_____Date: