Migraine Action Plan

Please complete this form for student's migraine headaches so staff can provide care at school.

Student name: ______________________________ **DOB:** ____________________

School: ______________________ **Grade:** _______________ **School year:** ____________________

List Triggers

____

____

List Symptoms and Frequency

____

____

____

Symptoms are tolerable when pain level is 1-10 with (10 being the worst pain imaginable) **_____.**

Medical Alert – Migraine Treatment Plan

Check all applicable

- ☐ Contact me prior to medicating.
- ☐ Give medication.
- ☐ My student should return to class after taking medication .
- ☐ My student needs to sleep or rest in a dark, quiet area for up to 45 minutes after taking medication.
- ☐ My student can return to class when pain level is_______ (1-10 with 10 being the worst pain imaginable).
- ☐ My student may self-carry migraine rescue medication.

Rescue Medication Orders

Medicine	Dosage	Time/Frequency

Effective Date: From: ______________________ **To:** ________________________

Provider
Comments:____

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____

I give permission for school personnel to administer the above listed medications as ordered to my student for the duration of the current school year. I give permission to share this information with staff on a need to know basis. ***Signature(s) required for medication to be administered at school.***

Parent/Guardian Signature: ______________________________**Phone#:**____________________**Date**____________

Physician Signature: ____ **Date:** ______________________

Physician address/phone number: ____