Cleburne ISD
Migraine/Headache School Health Plan

Student Name: _____ DOB: _____

Physician Name: _____ Phone# _____
(Print)
Physician Signature: _____ Fax# _____

Medical Dx: _____
__ No known allergies __ Allergies:*List* _____

Medication: _____

Rest/Restrictions: _____

Frequency.typical signs/symptoms: _____

Presenting/typical signs/symptoms: _____

Triggers,precipitating factors: _____

Ability to anticipate signs and symptoms of impending migraine
__Independent __Requires supervision/assistance __Dependent

Ability to select appropriate treatments based on symptom severity:
__Indpendent __Requires supervision/assistance __Dependent