Acalanes Union High School District

1212 Pleasant Hill Road, Lafayette, California 94549

MIGRAINE ACTION PLAN

Student's Name: _____**Birth Date**: _____

Allergy to: _____

This student has been diagnosed with Migraine headaches and has medically prescribed interventions.

SIGNS OF MIGRAINE MAY INCLUDE:

- ☐ Moderate to severe pain that can be throbbing or/or disabling
- ☐ Nausea and/or vomiting
- ☐ Visual disturbances: _____
- ☐ Photophobia (light sensitivity)
- ☐ Phonophobia (sound sensitivity)
- ☐ Neurological symptoms: _____
- ☐ Other: _____

KNOWN TRIGGERS: _____

If student is experiencing these symptoms, please send student to School Nurse office with an escort.

1. **MEDICATION** to be given for Migraine Management

Medication	Dosage (mg or ml)	Timing of dose	Route	Special Instructions

2. **REST**: Allow student to rest in School Nurse's Office (dark, quiet conditions preferred) until symptoms improve sufficiently for student to return to class
3. **DISMISSAL HOME**: If symptoms do not improve within 30 minutes, contact parent for dismissal home

EMERGENCY CARE PARAMETERS: _____

Absences related to migraine symptom management are medically excused.
Students are encouraged to keep a log of symptoms and treatment effectiveness for review with your provider.

To be completed by the Parent/Guardian:

California Education Code Section 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. The parent/guardian is responsible for providing the medication, which should be sent in the original bottle and labeled with the student's name.
I request that medication be administered to my child in accordance with our authorized health care provider written instruction. I understand that designated non-medical personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible side effects.

I agree with the above Migraine Action Plan: _____ Date: _____

Authorizing MD NAME: _____

MD SIGNATURE: _____ **Date**: _____

Office stamp (name, address, phone)

Medical authorizations require annual renewal by provider and parent