Bellevue School District Migraine Individual Health Plan

Name:	_____	Birth Date:	_____	
School:	_____	Grade	_____	

Migraine Headaches: A headache characterized by severe pain. It can be accompanied by nausea, vomiting, light and sound sensitivity.

COMMON TRIGGERS:

☐ Poor sleep ☐ Skipping meals ☐ Dehydrated
☐ Too much caffeine ☐ Skipping daily medication
☐ Stress
☐ Other: _____

COMMON SYMPTOMS:

☐ Nausea/vomiting ☐ Dizziness ☐ Light sensitivity
☐ Noise sensitivity ☐ Difficulty focusing
☐ Visual disturbance/aura ☐ Fatigue
☐ Other: _____

EMERGENCY CARE PLAN

CALL 911 IF SUDDEN/SEVERE/WORST EVER HEADACHE, NEW NEUROLOGICAL SYMPTOMS, FEVER OR NECK STIFFNESS, PERSISTENT VOMITING, OR DETERIORATING SYMPTOMS

Green Zone: No headache or migraine and can participate in regular activities.

Yellow Zone: I have symptoms of a migraine/headache. Please see medication below for treatment. Consider resting in darker, quiet room.

Red Zone: I feel bad and have a migraine AND red flag symptoms (sudden onset of unusual headache; severe headache with fever; if student fell or had a head bump before the headache started). Call 911 and/or parent.

MEDICATION/TREATMENT ORDERS: *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM. IHP can be filled out by School Nurse based on BSD "Medication Authorization Form – 3416P Exhibit A" or other completed provider orders. *In accordance with RCW 18.79.040, if a registered nurse is on site, they may utilize the nursing process, which includes assessment, specialized knowledge, judgment, and skill in determining plan of care or treatment.*

	Medication #1	Medication #2
MEDICATION name:	_____	_____
DOSE:	_____	_____
ROUTE, circle one:	Oral / Inhaler /Topical/ Injection- Specify IM or Subcutaneous / Eye drops / Ear drops / Other	Oral / Inhaler /Topical/ Injection- Specify IM or Subcutaneous / Eye drops / Ear drops / Other
Reason/Diagnosis	_____	_____
Time of dose:	_____	_____
Side effects:	_____	_____
When to repeat?	_____	_____

SELF CARRY, HEALTH CARE PROVIDER please check one box & sign below *(BSD staff has been trained to assist with medication administration):*

☐ **YES**** student may SELF CARRY. ☐ **YES**** student may SELF ADMINISTER.

****Checking "Yes"** indicates that student has been thoroughly instructed in the purpose and appropriate method/frequency of use and/or safe carrying and/or administration of medication. Student/parent/guardian/provider understand the responsibilities of self-carrying and self-administering at school. *Middle and high school students are encouraged to self-carry and self-administer medication as possible.*

☐ **NO**, student MAY NOT self carry. ☐ **NO**, student MAY NOT SELF ADMINISTER.

PROVIDER- PLEASE SEE BELOW FOR AUTHORIZATION AND SIGNATURE

Licensed Health Care Provider's signature:	**Date:**	_____	**Phone:**	_____
_____	**School year:**		**Fax:**	_____
Signature authorizes medication for length of school year				

PARENT/GUARDIAN/STUDENT (age 18 and older) RESPONSIBILITIES:

- I will notify the school nurse of any changes in health status or healthcare provider instructions.
- I will keep track of expiration dates for the medication(s) and replace if expired or used.
- I will provide prescription medication(s) in original pharmacy container labeled with student name, medication name, strength of medication, dose, and time of administration OR I will provide non-prescription medication in the original container with the student name.
- I understand for "self-carrying" medication, back-up medication in the health room is recommended.
- Students who "self-carry" medication are responsible for carrying medication during school and for all school clubs, activities, sports, field trips.
- If my student attends extended day/childcare, clubs before- and after-school, evening, and summer activities, I will notify the program director of my student's medication and health care needs.

PARENT/GUARDIAN/STUDENT (age 18 and older) - Please check only one box & sign below:

☐ I request that I/my student be allowed to **self-carry and/or self-administer this medication**.

☐ If I do not/my student DOES NOT self-carry, I request that the authorized/trained person(s) at school assist me/my student in taking the medicine(s) described above.

If I/my student has permission to SELF-CARRY and/or SELF-ADMINISTER THIS MEDICATION I/my student understands the responsibility of self-carrying medication at school and recognizes the school will not track compliance, expiration, or amount.

I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of any injury resulting from reasonable and prudent administration of medication, the reasonable performance of health care procedures, or the liabilities arising out of self-administration and self-carrying of medication by my student/me. BSD staff have been trained to assist with medication administration.

I accept this Individual Health Plan. *My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.*

Parent/Guardian/Student (age 18) signature: _____	**Date:**		**Phone:**	

INDIVIDUAL CONSIDERATIONS:

Classroom:

- Teacher to inform substitute teachers of the student's Individual Health Plan

Field Trip Procedures: Students who self-carry are responsible for their own medication. Medication and IHP will accompany student during any off-campus activity.

School Nurse: Will notify teachers, other school staff, transportation, and nutrition services of student's IHP

Please return to:

School Nurse: _____	**Email:**	_____@bsd405.org	**Phone:**	425-456-____
			Fax:	425-456-____

Updated 2/23/26

See also BSD Policy/Procedures: 2410 Student Health; 3411 Life Threatening Health Conditions; 3413 Student Immunization and Life-Threatening Health Conditions; 3416 Medication at School; 3418 Emergency Treatment