Farmington Municipal Schools Health Services
Migraine Action Plan

Parent/Guardian: Please complete information in this top section and sign authorization at the bottom of the page.				
Student Name	**DOB**	**Age**	**Grade**	**Medication Allergies**
Prescriber Name		**Prescriber Phone**		
Parent/Guardian Name		**Parent/Guardian Phone**		
Emergency Contact		**Emergency Contact Phone**		
Describe aura (if any):				

Prescriber: Please complete Zone Information and Authorization below.

Green Zone: Prevent more headaches.

Do or take this every day to help prevent YOUR headaches:

It may take 4-6 weeks to see a big change, so stick with it!

- ☐ _____
- ☐ _____
- ☐ Get enough sleep; keep a regular schedule
- ☐ Eat healthy foods; don't skip meals
- ☐ Drink enough water; avoid caffeine
- ☐ Get regular exercise
- ☐ Learn ways to relax; manage stress

Yellow Zone: Don't Wait. Act fast to treat your headaches.

Go to **school health office** right away. Take this quick-relief medicine as soon as your headache starts:

Let your provider know if you need to take your quick-relief medicine 3 or more days a week or if this plan isn't working.

- ☐ _____, dose: _____, every _____ minutes / hours PRN for pain level: _____ (circle)
- ☐ _____, dose: _____, every _____ minutes / hours PRN for pain level: _____ (circle)
- ☐ Drink _____ oz. water or sports drink: _____
- ☐ Rest in a dark, quiet place for _____ minutes / hours
- ☐ Modified physical activity for the day: _____

Red Zone: Time to get more help.

- Contact your **prescriber's office** if your headache is much worse or lasting longer than normal.
- Go to the **Emergency Room or Call 911** if your child loses consciousness or has new and very different symptoms like loss of vision, inability to move one side of your face or body, trouble walking or talking, very confused or inability to respond.

AUTHORIZATION

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact the prescriber, if necessary. I assume full responsibility for providing the school with the prescribed medications and any other items necessary for my student's care. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

I want to be notified any time a medication on this form is administered to my student ☐ Yes ☐ No

I confirm student is capable to safely carry and properly administer above medication(s) ☐ Yes ☐ No

If yes, see school nurse for additional paperwork

Prescriber Signature: _____

Date: _____

- ☐ Administration of medication by trained staff
- ☐ Student may self-administer under direct supervision
- ☐ Student may self-carry and self-administer medication

School Nurse Signature: _____ **Date:** _____

Potential for acute pain related to neurovascular changes

Goal: Pain reduction and return to class

Revised: 03/2026