MIGRAINE INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

NEUROLOGIST _____ PHONE _____

How often does your child have a migraine headache?

How long do your child's migraines usually last?

Does your child have a known trigger(s) for their migraines? ☐ Yes ☐ No Please check all that apply:

- ☐ Hunger
- ☐ Lack of sleep
- ☐ Oversleeping
- ☐ Weather changes
- ☐ Physical activity
- ☐ Stress
- ☐ Physical illness
- ☐ Dehydration
- ☐ Specific food(s) or drink(s): _____
- ☐ Loud noises
- ☐ Various odors
- ☐ Other: _____

Does your child experience an aura with migraine headaches? ☐ Yes ☐ No If yes, please describe:

Does your child take a medication at home every day to keep their migraines controlled? ☐ Yes ☐ No If yes, what medication?

Does your child have a doctor's order for medication for a migraine to be given at school, and is the medication at school?
☐ Yes ☐ No

Is there anything else your child does at home that helps with a migraine? ☐ Yes ☐ No If yes, please describe:

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's migraines and have knowledge of how to manage a migraine. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their migraines.*

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's migraines?

PLEASE NOTE: We recommend talking with your child's doctor to see if they recommend an Emergency Action Plan. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

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STUDENT NAME _____
MIGRAINE TRIGGERS _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

☐ Mild, moderate or severe pain in the head
☐ Throbbing or pounding pain
☐ Nausea and/or vomiting
☐ Sensitivity to light
☐ Sensitivity to sound
☐ Dizziness
☐ One-sided sensory changes, called an aura, which may include changes in vision, numbness or tingling
☐ Other: _____

Interventions:

1. Allow student to rest in a dark, quiet space.
2. Administer medication, if prescribed, at onset of symptoms

   Medication: _____
3. Allow access to water and snack, as needed.
4. Call 911 if needed. Notify front office to direct EMS to student's location.
5. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.
6. Notify parents/guardians if needed, or designate another staff member to notify:
   a. Parent/guardian name: _____ Phone number: _____
   b. Emergency contact name: _____ Phone number: _____
7. Notify school nurse.

Additional information:

_____

_____

_____

Reference: https://www.chop.edu/conditions-diseases/headaches-children Revised 4/2020 ALB