Migraine Care Plan

Student Name:_____ DOB:_____

Parent:_____ Phone:_____

Physician:_____ Phone:_____

The above student has been diagnosed with migraine headaches. Migraines in this student are often identified by the following characteristics (check all that apply):

- □ Moderate to severe pain intensity
- □ Throbbing pain
- □ Light sensitivity
- □ Sound sensitivity
- □ Nausea
- □ Vomiting

Other:_____

1st medication to be given:
Medication Name:_____

Dose:_____ Route:_____

Frequency:_____

2nd medication to be given: □ N/A
Medication Name:_____

Dose:_____ Route:_____

Frequency:_____

Medication is authorized: □ To be administered by school personnel □ To be self-administered by student

Medication should be given as soon as the child recognizes the onset of a migraine, without delay.
If needed, please allow the child to rest for 30-45 minutes in a dark, quiet place. After this time the student may return to the classroom if pain relief is achieved or if the child feels they can continue to function.
Please notify the parent if:

- ✱ Heachache does not respond to treatment within 2 hours
- ✱ Headaches seem to be increasing in frequency
- ✱ School is low on medication
- ✱ There are any other concerns
- ✱ Headaches have a sudden change in characteristics or features

Call 911 If Student Has any of the following:

- ✱ loss of vision
- ✱ unable to move one side of their face or body
- ✱ trouble walking or talking
- ✱ very confused or unable to respond.

Parent Signature:_____ Date:_____

Physician Name:_____ Date:_____

Nurse Signature:_____ Date:_____