MIGRAINE Action Plan

SCHOOL:__________________________________ **SCHOOL YEAR:** _______________

Student:________________________________ Date of Birth _____/_____/_____

Grade: _____ **Teacher:** ____________________ **Physician**____________________ **Phone**_______________

Emergency Contacts

MOTHER	FATHER
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
If parents cannot be reached call:	
Name:	Phone:
Name:	Phone:
Physician:	Phone:

STUDENT HISTORY/MEDS:

SYMPTOMS (Check those that apply):	TRIGGERS:
__Auras/visual disturbances	__Hunger
__Nausea/vomiting	__Lack of sleep
__Throbbing pain	__Stress
__Dizziness	__Hormonal changes
__Sensitivity to light/loud sounds	__Certain foods
__Numbness or tingling of extremities	__Pain relief medications if used too much
__Other:	__Bright lights/computer lights/loud noises
	__Other:

MANAGEMENT:

1. Avoid known triggers
2. Rest/ dim the lights/quiet music ________________________________
3. Deep breathing/ relaxation techniques ________________________________
4. Cold pack/compress to forehead ________________________________
5. Medications as provided by parents
6. Other: __________________________

CALL PARENT IF:

1. Headache does not improve, or worsens
2. Vomiting
3. Other: ____

CALL 911 IF:

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.

Copy of this plan has been provided to:____

________________________________ ________________________________

PARENT SIGNATURE NURSE SIGNATURE 3-18-14