

SCHOOL GUIDELINES FOR THE STUDENT WITH MIGRAINES

Student Name _____ DOB _____ Date _____
School _____ Grade _____ Teacher _____

EMERGENCY CONTACT INFORMATION DURING SCHOOL HOURS

Mother's Name _____ Phone Number _____

Father's Name _____ Phone Number _____

In case of emergency and parents cannot be contacted, please call:

Name _____ Relation _____ Phone _____

MEDICATIONS AT SCHOOL-Including over the counter And Prescription medications

1. Over the Counter Medication _____

Dose _____ Time _____

2. Prescription Medication _____

Dose _____ Time _____

PLAN OF CARE FOR SCHOOL PERSONNEL

1. Identify triggers that might precipitate a headache.

Triggers: _____

2. If headache occurs, move student to a quiet, dimly lit area.

3. Note time of onset of headache and area of pain.

4. Administer medications as ordered by physician/parent. (See above)

5. Apply ice bags YES/NO (circle one).

6. Notify parents as needed or if no improvement in headache.

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____

