RETURN TO SCHOOL NURSE

SCHOOL GUIDELINES FOR THE STUDENT WITH MIGRAINES

Student Name_____DOB_____Date_____
School_____Grade_____Teacher/Team_____

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

Please list specific triggers and symptoms:
_____
_____

TRIGGERS:

*hormonal changes	*sensory stimulation (lights, noise, etc)
*lack of sleep	*physical activity
*foods_____	*medications
*stress	*changes in environment

SYMPTOMS:

*pain	*lightheadedness
*vision changes	*changes in speech
*nausea/vomiting	*sensitivity to light

Medications at School:

1. Over-the Counter Medication_____ Dose_____
   Special Instructions_____
   _____

2. Prescription Medication _____Dose_____
   Special Instructions_____
   _____

At first signs of these symptoms please follow these instructions:

1. Move student to a quiet, dimly lit area.
2. Note time of onset of headache and area of pain.
3. Administer medications as ordered by physician/parent.
4. May apply cold compress. **YES/NO**
5. Notify parents as needed or if no improvement in headache.

Parent Signature_____ Date_____

School Nurse_____ Date_____