



Student Services

Health Care Action Plan—Migraines

Please return form to: _____
School _____ Fax _____

Name: _____ DOB: _____

ID#: _____ Grade: _____ Parent/Guardian: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: (mother) _____ (father) _____

Emergency Contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Specialist: _____ Phone: _____

Symptoms and History of Migraines (include age of onset, aura or prodromal symptoms, if nausea or vomiting occurs, visual changes etc)

Medications Available at School for Treatment

Interventions:

1. Allow to rest, preferably in a quiet, darkened room for 20 minutes after taking medication, if needed.
2. If medication isn't taken soon enough and symptoms aren't relieved, notify parents.

Restrictions/Precautions

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

School Nurse Date Parent/Guardian Date Health Care Provider Date