Migraine Headache
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

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

DEFINITION: Migraine headaches are frequently referred to as vascular headaches. The blood vessels in the head either constrict and become narrow, or expand and dilate causing a headache and a variety of other symptoms. Often there is a family history of migraines.

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:

School Clinic: Please provide a copy of plan to Transportation Supervisor

_____ _____

PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

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