



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