Migraine Health Care Plan

Student Name:
DOB:

School:
Grade:

The above student has been diagnosed with migraine headaches. Migraines in this student are often identified by the following characteristics (circle all that apply):

Moderate to severe pain intensity
Throbbing pain
Photophobia (light sensitivity)
Phonophobia (sound sensitivity)
Nausea and/or vomiting
Other:

Name and dose of 1st medication to be given:_____

Name and dose of 2nd medication to be given:_____

Additional treatment:_____

Medication should be given as soon as the child recognizes the onset of a migraine, without delay.

If needed, please allow the child to rest for 30-45 minutes. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.
Please notify the parent if:

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency
- You are running low on medication for the student
- You have any other concerns

Parent's Signature_____Date_____

School Nurse Signature_____Date_____