Migraine School Health Care Plan

Student Name:	School Year
Date of Birth	Grade/Teacher
Parent/Guardian	Phone #
Physician Name	Phone #
Emergency Contact 1	Phone #
Emergency Contact 2	Phone #

The above student has been diagnosed with migraine headaches. Migraines in this child are often identified by the following characteristics:

_____ Moderate to severe pain intensity
_____ Throbbing pain
_____ Disabling pain
_____ Nausea and/or vomiting
_____ Photophobia
_____ Phonophobia

This child has been prescribed: ***Give medication(s) at onset of migraine, without delay.***

Medication	Dosage	Time(s)	Route	Taken at Home or School
#1				
#2				
#3				

Potential side effects to watch for include: _____

If needed, please allow the child to rest for_____. 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 have any other concerns

Other notes:_____

******Please supply the school with the needed medication(s) on or prior to the first day of school******

- I hereby give permission to MTSD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician with any concerns regarding medication administration. I agree to hold the Mequon-Thiensville School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named physician (office) to send by electronic transmission this form to the Mequon-Thiensville School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

_____

Parent's Signature **Date**

FOR INHALED/PRESCRIPTION MEDICATIONS

☐ I have instructed _____in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

Where will the medication be kept during school: _____

☐ It is my professional opinion that _____should not carry his/her medication by him/herself.

_____ _____

Physician's Signature **Date** **District Nurse Signature** **Date**