



**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): ___ Auras/visual disturbances ___ Nausea/vomiting ___ Throbbing pain ___ Dizziness ___ Sensitivity to light/loud sounds ___ Numbness or tingling of extremities ___ Other: _____	TRIGGERS: ___ Hunger ___ Lack of sleep ___ Stress ___ Hormonal changes ___ Certain foods ___ Pain relief medications if used too much ___ 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:	

Copy of this plan has been provided to Transportation Supervisor Yes No

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.