MIGRAINE HEADACHES
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: ____

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Medications (list all medications taken):	Dose:	Time:

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:
- Avoid known triggers
- Rest/ dim the lights/quiet music
- Deep breathing/ relaxation techniques
- Cold pack/compress to forehead
- Medications as provided by parents

Other: ______________________________

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CALL PARENT IF:
1. **Headache does not improve, or worsens**
2. **Vomiting**
3. **Other:** ____

CALL 911 IF:

School Clinic: Copy of this plan to be provided to Transportation Supervisor

______________________________ ______________________________

PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Information about students and family is strictly confidential.