GreatHearts
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.

Migraine Health Care Plan

Name of Child: ___________________________________

Physician Name: __________________________________

Physician Contact information: _______________________

Date Instructions Provided: __________________________

School Nurse Instruction Form

The child ________________________ has been diagnosed with Migraine Headaches. Migraines in this child are often identified by the following characteristics:

__________Moderate to severe pain intensity
__________Throbbing pain
__________Photophobia
__________Phonophobia
__________Disabling pain
__________Nausea and/or vomiting

The child has been prescribed: ____________________________

Name of medication #1 to administer: _____________________
Dose of medication #1 to administer: _______________________

Name of medication #2 to administer: ________________________
Dose of medication #2 to administer: _________________________

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

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 are running low on medication prescribed for this child
- You have any other concerns

Physician Signature: ___________________________________ Date____________

Parent's Signature: ___________________________________ Date____________