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POUDRE SCHOOL DISTRICT

**Pupil Services**

# Health Care Action Plan—Migraines

**Please return form to:** _____ School _____ Fax

Name: _____ DOB: _____

ID#: _____ Grade: _____ Parent/Guardian: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Work phone: (mother) _____ (father) _____

Emergency contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Specialist: _____ Phone: _____

**Diagnosis: Migraines/Headaches**

**Brief Health History:** (include age of onset, aura or prodromal symptoms, if nausea or vomiting occurs, visual changes etc) _____

_____

_____

_____

**Medication/dose/frequency:** _____

Medication must be taken with onset of symptoms.

**Interventions:**

1. Allow to rest, preferably in a quiet, darkened room for 20 minutes after taking medication, if needed.
2. If medication isn't taken soon enough and symptoms aren't relieved, notify parents.

**Restrictions/precautions:** _____

_____

_____

_____

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

| School Nurse | Date | Parent/Guardian | Date | Health Care Provider | Date |
|---|---|---|---|---|---|

Rev. 5/1/03