

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\_\_\_\_\_\_\_\_\_\_\_\_