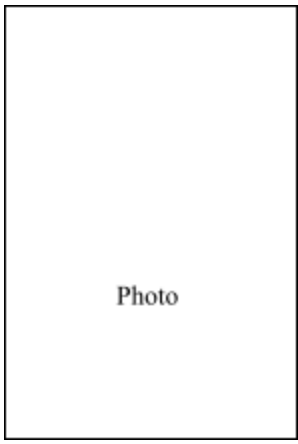
School Nursing
Migraine Emergency Action Plan



Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____date of birth_____
request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours. And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes.
4. I will assume responsibility for safe delivery of the medication to school
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization.

My child has been diagnosed with migraine headaches. The goal is to keep him/her in school and able to concentrate/participate in school activities.

Triggers: (parent to complete)

□ Missing a meal	□ Sleep –oversleeping/lack of	□ Lights/strobe or flashing
□ Weather changes	□ Stress	□ Physical illness
□ Exertion	□ Various odors	□ Loud/continuous noises

□Certain foods/drink(specify): _____

Other:_____

Migraine Symptoms

_____

_____

Treatment should begin with the first symptom for medication to be effective. Student should be allowed to rest for at least 20 minutes after medication.

Notify parent: □ at onset □ if no relief in 1 hour □_____

MEDICATIONS TO BE GIVEN AT SCHOOL:

Name of Medication	Dosage	When To Use

MEDICATIONS GIVEN AT HOME:

Name of Medication	

Non-Pharmaceutical treatments:
□ Water □ Rest
□ Food □ Other_____

Signature of
Parent/Guardian: _____ Relationship: _____ Date: _____
Emergency Contact phone number:_____

PLEASE REVIEW PARENT PROVIDED INFORMATION, SIGN AND RETURN

_____ _____
Physician's name printed **Physician's signature**

Physician's address: _____
Phone: _____ Fax: _____ Date: _____