# Migraine Headache Action Plan

Please complete this form for your child's migraine headaches so staff can provide care at school.

**Student name:** ______________________ **Grade:** ______________

**School:** ______________________ **School year:** ______________

**If your child's migraine headaches are resolved and no longer a medical concern, check the box and sign below.**

☐ My child's migraine headaches are resolved.

Parent signature: ______________________ Date: ______________

## Preventive Headache Treatment

### Daily Migraine Control Medications

| Medicine | Dose | Time Given |
|---|---|---|
| | | |
| | | |

**Triggers (Check all applicable)**

☐ Fatigue
☐ Stress
☐ Food — *Specify:* ______________
☐ Exposure to light (bright lights, sun, strobe lights)
☐ Other — *Specify:* ______________
☐ Unknown

**Symptoms (Check all applicable)**

☐ Aura — *Describe:* ______________
☐ Sudden onset of an intense headache — *Location:* ______________
☐ Nausea and vomiting
☐ Dizziness
☐ Vision changes (e.g. blurred vision, dark spots) — *Specify:* ______________
☐ Sensitivity to light, computer screens and/or overhead lights
☐ Fatigue
☐ Other: ______________

**Symptom Frequency (Check all applicable)**

☐ Daily ☐ Weekly ☐ Several times a month
☐ Periodically (headache pattern is unpredictable)

## Medical Alert – Migraine Headache Treatment Plan

Check all applicable

☐ Call me if my child has a headache
☐ Give medication

### Migraine Relief Medications

| Medicine | Dose and amount given |
|---|---|
| | |
| | |
| | |

*Complete and sign backside of form*

**Check all applicable**

- ☐ My child can return to class after taking the medication.
- ☐ My child needs to sleep or rest in a dark, quiet area for an hour after taking his/her medication.
- ☐ Call the parent or guardian if the headache is not gone after resting for 30-60 minutes.

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I verify that the above information is correct. I give my permission to share this information with staff on a need-to-know basis.

**The information is valid for ONE school year. Annual parent and physician signatures are required. Parents are responsible for obtaining physician signature.**

Parent signature: ______________________________ Date: ______________

Physician signature: ______________________________ Date: ______________