Migraine Health Care Plan

**Name of Child:** ____________________________

**Physician Name:** ____________________________

**Physician Contact information:** _______________________

**Date Instructions Provided:** ____________________________

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**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 parents 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**________