HEALTH MANAGEMENT PLAN MIGRAINE HEADACHES SCHOOL YEAR:_______________

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

CONTACTS	
MOTHER:	FATHER:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
If parents cannot be reached call:	
Name:	Phone:
Name;	Phone:
Physician:	Phone:
Hospital Preference:	

DEFINITION: Migraine headaches are frequently referred to as vascular headaches. The blood vessels in the head either constrict and become narrow, or expand and dilate causing a headache and a variety of other symptoms. Often there is a family history of migraines.

STUDENT HISTORY: ____

____

Medications (list all medications taken):		Time:

SYMPTOMS (Check those that apply):	TRIGGERS:
____Auras/visual disturbances	____Hunger
____Nausea/vomiting	____Lack Of sleep
____Throbbing pain	____Stress
____Dizziness	____Hormonal changes
____Sensitivity to light/loud sounds	____Certain foods
____Numbness or tingling Of extremities	____pain relief medications if used too much
____Other:	____Bright lights/computer lights/loud noises
	____Other:

MANAGEMENT:
1. Avoid known triggers: 2. Rest/ dim the lights/quiet music 3. Deep breathing/ relaxation techniques 4. Cold pack]compress to forehead 5. Medications as provided by parents 6. Other
CALL PARENT IF: l. Headache does not improve, or worsens 2. Vomiting 3. Other;
CALL 911 IF:

School Clinic: Copy of this plan should be provided to Transportation Supervisor.

PARENT SIGNATURE / DATE

COUNTY SCHOOL NURSE SIGNATURE / DATE

Confidentiality Of health Should be maintained at all times.

Rev.