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):	**Dose:**	**Time:**

SYMPTOMS (Check those that apply): **__Auras/visual disturbances** **__Nausea/vomiting** **__Throbbing pain** **__Dizziness** **__Sensitivity to light/loud sounds** **__Numbness or tingling of extremities** **__Other:**	**TRIGGERS:** **__Hunger** **__Lack of sleep** **__Stress** **__Hormonal changes** **__Certain foods** **__Pain relief medications if used too much** **__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:

1. **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 must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.