MIGRAINE/HEADACHE HEALTH PLAN

|  |  |
| --- | --- |
| Student Name |       |
| Grade |       |
| Parent/Guardian Name |       |
| Phone # |       | Email |       |
| Health Care Provider Name |       |
| Phone # |       | Email |       |

**The Following to be Completed by Health Care Provider:**

Based on the healthcare provider’s evaluation, this student was diagnosed with migraines/headaches.

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|       |

**Symptoms related to migraine/headaches:**

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| --- | --- |
| [ ]  Headache[ ]  Cognitive Difficulties[ ]  Sensitivity to Light[ ]  Dizziness[ ]  Fatigue | [ ]  Sleep Difficulties [ ]  Nausea/ Vomiting[ ]  Visual Dysfunction[ ]  Sensitivity to Noise[ ]  Foggy |

**Current Lifestyle Changes to Manage Migraines/Headaches:**

|  |  |
| --- | --- |
| [ ]  Less Screen Time[ ]  Good Sleep Hygiene[ ]  Stay Hydrated | [ ]  FL 41 Tinted Glasses[ ]  Manage Stress[ ]  Fragrance Free |
| [ ]  Eating Migraine Healthy Meals  |       |
| [ ]  Avoid Environmental Sensitivities |       |
| Known Triggers |       |

**Medical Adjustments: It is medically necessary for this medication to be given during school hours.**

|  |  |
| --- | --- |
| [ ]  Allow water and food intake as needed | [ ]  Allow access to medication at onset/worsening of migraine or headache |
| [ ]  Allow to rest in a quiet, dark, or dimly lit room | [ ]  Provide cool compress or ice to neck or head |
| [ ]  Allow student to contact parent | [ ]  Contact parent 1 hour after medication administration if no improvement |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **ROUTE** | **TIME** | **COMMENTS** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

***I understand medication administration may be carried out by school personnel who have been delegated to perform these duties and trained by the school nurse.*** *Parents agree to notify the school nurse of any medication changes and will provide the school with the medication in the original container.*

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|       |  |       |
| Healthcare Provider Name | Healthcare Provider’s Signature | Date |

|  |  |  |
| --- | --- | --- |
|       |  |       |
| School Nurse Name | School Nurse’s Signature | Date |

|  |  |  |
| --- | --- | --- |
|       |  |       |
| Parent/Guardian Name | Parent/Guardian’s Signature | Date |

**ACADEMIC ADJUSTMENTS *(To be completed in partnership by family and school/school nurse)***

The following academic adjustments may help the student to better participate in the academic process. **The student and parent are encouraged to discuss and establish adjustments with the school on a class-by-class basis.**

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| **Attendance Adjustments** |
| [ ]  Full/partial days missed due to migraine/headache symptoms should be medically excused[ ]  Schedule non-critical classes in the morning[ ]  Modified days/late start days |
| Notes:       |
| **Note Taking** |
| [ ]  Provide study guides[ ]  Peer and/or teacher notes to supplement missed classroom time |
| Notes:       |

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| **Breaks** |
| [ ]  Student may need to go to the nurse/counseling office to rest in a quiet, dark, or dimly lit room.[ ]  May provide a cool compress or ice to head or neck[ ]  Allow access to school counselor/social worker for anxiety/depression |
| Notes:       |

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| **Other Adjustments** |
| [ ]  Allow for snacks and drinks[ ]  Allow liberal bathroom privileges[ ]  Allow excusal from assemblies[ ]  No MSG, artificial sweeteners, or dyes.[ ]  Allow to wear earplugs or headphones when experiencing phonophobia[ ]  Home-based instruction for extended absence or hospitalization[ ]  Allow student to wear hat/sunglasses (sensitivity to light)[ ]  Change brightness/contrast setting on computer[ ]  Allow to leave class without permission for nausea/vomiting[ ]  Lunchroom Accommodations  |
| Lunchroom Accommodations details if checked:       |
| Additional Adjustments:       |

*By signing, I give my consent for my child to receive the services as outlined in this plan.*

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|  |  |
| Parent/Guardian Date | Student Date |
|  |  |
| Case Manager/School Nurse Date | Administrator Date |

This form was created by Migraine at School, a national initatve of the Danielle Byron Henry Migraine Foundation. Learn more at migraineatschool.org