MIGRAINE/HEADACHE HEALTH PLAN

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| --- | --- | --- | --- |
| 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:**

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| --- | --- | --- |
| 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.**

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| --- | --- |
| 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 |

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