

Handling Migraines at School Form for School Nurse

Being prepared is essential to Migraine management and treatment.

This form is intended to be used to provide information to school nurses who may need to know about the Migraines children and adolescents may have at school. Some schools no longer have school nurses, but there will be someone in the school office who can tell you who should receive this form and any accompanying medications.

This form should be completed and taken to school at the beginning of each school year and whenever the student's medications, information, or needs change.



Teri Robert

Information for School Nurse

My child, _____, has been diagnosed with Migraine disease. During a Migraine attack, my child may experience:

- | | |
|---|---|
| <input type="checkbox"/> moderate to severe head pain | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> sensitivity to light | <input type="checkbox"/> sensitivity to sound |
| <input type="checkbox"/> visual distortions | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> aphasia | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> mood changes | <input type="checkbox"/> tiredness/sleepiness |
| <input type="checkbox"/> other: _____ | |

When my child experiences a Migraine attack, it is important that he/she take medication as soon as possible. The following medication(s) have been prescribed by my child's physician to be taken when he/she has a Migraine attack:

Name of medication: _____

Dosage/directions: _____

Name of medication: _____

Dosage/directions: _____

Potential side effects to watch for: _____

Please contact parent if...

- my child reports symptoms that are unusual for him/her or are extreme.
- my child's medication does not provide relief within two hours.
- my child's Migraines seem to be increasing in frequency or severity.
- you need more of my child's medications.
- you wish to discuss anything related to my child's health.

To verify this information for you, my child's physician has also signed below. Thank you!

Parent's Signature

Date

Parent's Name (Printed)

Phone Number

Physician's Signature

Date

Physician's Name (Printed)

Phone Number