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):	**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:

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.

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