GreatHearts
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.

Migraine Health Care Plan

Name of Child: _____

Physician Name: _____

Physician Contact information: _____

Date Instructions Provided: _____

School Nurse Instruction Form

The child _____ has been diagnosed with Migraine Headaches. Migraines in this child are often identified by the following characteristics:

_____Moderate to severe pain intensity
_____Throbbing pain
_____Photophobia
_____Phonophobia
_____Disabling pain
_____Nausea and/or vomiting

The child has been prescribed: _____

Name of medication #1 to administer: _____
Dose of medication #1 to administer: _____

Name of medication #2 to administer: _____
Dose of medication #2 to administer: _____

This medication should be given as soon as the child recognizes the onset of a migraine, without delay.

Potential side effects to watch for include:

_____

If needed, please allow the child to rest for_____.
After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

Please notify the parent if:

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency
- You are running low on medication prescribed for this child
- You have any other concerns

Physician Signature: _____ Date_____

Parent's Signature: _____ Date_____