# Migraine Headache
## Health Management Plan

**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/MEDS:** _____

_____

_____

| **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:**

**Copy of this plan has been provided to Transportation Supervisor Yes □ No □**

_____ _____

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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