Halifax County Schools
Student Health Services

Health Plan – Headaches/Migraines
School Year:

Student _____

_____ Date of Birth _____

_____ Grade _____

Parent/Legal Guardian _____

_____ Phone # _____

_____

School _____

_____ Teachers _____

_____

To be completed by parent/guardian:

IF YOU SEE THIS	DO THIS
Headache/Migraine	♦ Allow student to receive medication, if ordered by healthcare provider. Location of medication: □ Health room □ Other_____ ♦ Call parent to bring medication if no medication is available at school. ♦ Rest head on desk 15-20 minutes. ♦ Cool compress to forehead. ♦ Contact nurse or first responder if no improvement.
Bright light can cause headache to worsen.	♦ Allow to rest in dimly lit room, if feasible, for 30 minutes. ♦ If no improvement within one hour, call parent.
Nausea and/or vomiting	♦ Call parent if vomiting occurs. ♦ Do not give any medication if vomiting.

Please list the triggers/causes of severe headache/migraine. _____

How often does your child have headaches/migraines? _____

What usually helps with headache/migraine? _____

List medications/treatments that have been ordered: _____

Will medication need to be administered at school? □ Yes □ No If yes, see the school nurse for the Med. Form.

Is your child under a healthcare provider's care for the headaches/migraines? □ Yes □ No

If yes, name of healthcare provider _____ Phone # _____

Parent/Legal Guardian Signature _____ **Date** _____

To be completed by School Nurse

☐ Medication Administration Authorization Form completed by healthcare provider/parent.
☐ Reviewed and communicated to teachers and placed in EAP notebook.

Signature: _____ Date: _____