ACTION CARE PLANS FOR A STUDENT WITH SEVERE MIGRAINES/HEADACHES

Student:_____ Grade: _____
Date of Birth: _____ **Diagnosis:** _____

EMERGENCY INFORMATION:
Parent/Guardian's Name: _____
Mother: Telephone (H) _____ Father: Telephone (H)_____
Telephone (W)_____ Telephone (W)_____
Cell Phone_____ Cell Phone_____
Physician: _____ Telephone: _____
Address: _____

HISTORY: _____ Diagnosis Made: _____
Other current/chronic concerns: _____
Previous Hospitalizations: _____
Surgeries: _____

DESCRIPTION OF A TYPICAL HEADACHE/MIGRAINE_____
_____
Possible Triggers: _____
Average Length of Time a Headache Lasts: _____
Student Reaction to Headache: _____

ALL CURRENT MEDICATIONS (Please provide medication dispensing form if medication is to be given at school)

	NAME OF MEDICATION	DOSAGE	TIME	SIDE EFFECTS
1.				
2.				
3.				

ANY ADDITIONAL INFORMATION: _____

EMERGENCY TREATMENT:
*Notify Parents
*Given Medication as ordered
Comments or Miscellaneous Information:

PARENT SIGNATURE: _____ DATE: _____