The Brook Hill School
Christ-Centered. College Prep.

Migraine Individualized Health Plan

Student Name: _____ **Date of Birth** _____

Medications may be administered at school by the School Nurse when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that the School Nurse administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:
1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy
2. To provide the school with the written doctor's instructions for medication administration during school hours
3. To inform the school of any medical changes
4. To provide the school with this signed consent form annually and when changes in medication occur.

Signature of Parent/Guardian: _____
Relationship: _____ Date: _____

The above student has been diagnosed with migraine headaches. The goal is to keep the student in school and able to concentrate/participate in school activities.

Triggers: (parent to complete)

☐Missing a meal ☐Sleep - oversleeping ☐Sleep- lack of sleep ☐Lights/strobe or flashing

☐Weather changes ☐Stress ☐Physical illness ☐Exertion ☐Various odors

☐Loud/continuous noises ☐Certain foods/drinks ☐Menstrual Cycle

Specify Other Triggers:

Migraine Symptoms:

Usual length of migraines:
Date of last migraine: _____
Average frequency of migraines (daily, monthly, etc.):

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Treatment should begin with the first symptom for medication to be effective. Student should be allowed to rest for at least 20 minutes after medication. If no relief from headache in 1 hour, notify parent/guardian.

MEDICATIONS and DOSAGE TO BE GIVEN AT SCHOOL:

MEDICATIONS GIVEN AT HOME:

Physician Name (printed): _____ Phone #:_____Fax#:_____

Physician's Signature: _____ Date:_____