Migraine Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ Date of Birth: _____

Migraine Triggers: _____

Daily Medications: _____

1. Safe Zone:	**1. Action:**
Child has any of these: • No visible signs of pain • No additional warning signs • Denies pain/other symptoms • Can work/play	❑ Avoid triggers ❑ Allow desktop fluids and encourage fluid intake ❑ Allow extra bathroom breaks as needed

2. Caution Zone:	**2. Action:**
Child has any of these: • Complaints of head pain • Complaints of early migraine symptoms:_____ _____ • Difficulty with work/play	❑ Administer _____ medication(s). ❑ Encourage student to drink _____oz of water or sports drink. ❑ Call parent if medicine is used more than _____ times in one week. ❑ Call doctor if medicine is used more than _____times in one week.

3. Danger Zone:	**3. Action:**
Child has any of these: • Medicine not helping. • Vomiting	❑ Use _____medication. ❑ Notify parent. ❑ Notify doctor.

HealthCare Provider: _____ Phone#_____
(Please Print) Fax#_____
Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

Home Phone#_____ Work Phone#_____ Cell Phone#_____

It is the responsibility of the parent to notify the school and provide an updated copy upon any change to the plan.