

**Muscogee County School District
Student Health Services
MIGRAINE HEADACHES STUDENT HEALTH CARE PLAN**

Please mail or return to the school clinic.
A new health care plan is required every school year.
A physician's signature is required.

Student: _____ Date of Birth: _____ School year: _____

School: _____ Teacher: _____ Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Primary Healthcare Provider:		Phone Number:	

Check below the TRIGGERS that contribute to the onset of a migraine headache for this student:

- | | |
|--|--|
| <input type="checkbox"/> Missing a meal
<input type="checkbox"/> Weather changes
<input type="checkbox"/> Exertion
<input type="checkbox"/> Lack of sleep
<input type="checkbox"/> Stress
<input type="checkbox"/> Food/drink: _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Various odors
<input type="checkbox"/> Oversleeping
<input type="checkbox"/> Physical illness
<input type="checkbox"/> Loud/continuous noises
<input type="checkbox"/> Bright/flashing lights |
|--|--|

Check below the symptoms that require the IMMEDIATE need for this student to be excused from classroom activities:

- | | |
|--|--|
| <input type="checkbox"/> Headache on one side of the head
<input type="checkbox"/> Sensitivity to light/sound/odor
<input type="checkbox"/> Nausea with or without vomiting
<input type="checkbox"/> Aura/pre-migraine symptoms: _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Visual disturbances |
|--|--|

Management of Symptoms

Treatment should begin with the first symptom.

- Administer medication (a Medication Administration Authorization form must also be completed and signed)

Medication Name	Dosage(amount)/Time	When to use

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2. Allow student to rest in clinic for 30-45 minutes. After this time the student may return to class if pain relief is achieved or if the student feels they can continue to function.
3. Contact parent/guardian if:
 - Headache does not respond to given treatment within 2 hours
 - Headaches have a sudden change in characteristics or features
 - Headaches seem to be increasing in frequency
 - Medication supply for the student is low
 - Other: _____

Comments and Special Instructions (including school activities, sports, field trips, etc):

_____ _____ _____ _____

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____ **Phone Number:** _____

Physician's Signature: _____ **Date:** _____

Parent Consent for Management of Health Condition at School

I _____ (Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____ **Date:** _____