Place Child's Photo Here

Waller Independent School District
Health Services Department

Migraine Action Plan For School

Waller Independent School District

(To Be Completed By Health Care Provider and Parent)

Students Name	Date of Birth	Grade
Parent Guardian	Phone	Cell
Parent Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Migraine Triggers:		
Daily Medications at home:		

Medication

Name	Dosage	Time	How Often	Route	Comments

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 fluids. ❑ 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.

I agree with the recommendations of my child's HCP and authorize Waller ISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate Waller ISD employees for the current school year.

Physician Signature:	Printed Name:	Phone:	Date:
Parent Signature:	Printed Name:	Phone:	Date:

ADDENDUM to Action Plan

NURSE USE ONLY:

☐ Transportation Notified: Date Faxed _____

☐ Bus Driver Notified

☐ Added to Medical Alerts

☐ Self-Carry

☐ Diet Modification: Date Faxed _____

☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◊ TRAINED STAFF MEMBERS ◊ (To be completed by campuspersonnel)	
Teacher's Name:	**Date:**
Teacher's Name:	**Date:**
Administrator's Name:	**Date:**
Office Staff's Name:	**Date:**
Cafeteria Staff's Name:	**Date:**
Bus Driver's Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**

OTHER COMMENTS:

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____