

Place
Child's
Photo
Here

Waller Independent School District
Health Services Department
Migraine Action Plan For School



(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: Child has any of these: <ul style="list-style-type: none"> No visible signs of pain No additional warning signs Denies pain/other symptoms Can work/play 	1. Action: <ul style="list-style-type: none"> <input type="checkbox"/> Avoid triggers <input type="checkbox"/> Allow desktop fluids and encourage fluid intake <input type="checkbox"/> Allow extra bathroom breaks as needed
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2. Caution Zone: Child has any of these: <ul style="list-style-type: none"> Complaints of head pain Complaints of early migraine symptoms: _____ Difficulty with work/play 	2. Action: <ul style="list-style-type: none"> <input type="checkbox"/> Administer _____ medication(s). <input type="checkbox"/> Encourage student to drink fluids. <input type="checkbox"/> Call parent if medicine is used more than _____ times in one week. <input type="checkbox"/> Call doctor if medicine is used more than times in one week.
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3. Danger Zone: Child has any of these: <ul style="list-style-type: none"> Medicine not helping. Vomiting 	3. Action: <ul style="list-style-type: none"> <input type="checkbox"/> Use _____ medication. <input type="checkbox"/> Notify parent. <input type="checkbox"/> Notify doctor.
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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 campus personnel)

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: _____