Health Care Action Plan - Migraine

Please return form to: Resurrection Christian School Fax: 970 647 7385

Student Name _____ DOB _____ Grade _____

Address _____ City/State/Zip _____

Parent/Guardian _____ Home Phone _____

Work Phone (mother) _____ (father) _____

Emergency Contact _____ Phone _____

Primary Care Provider _____ Phone _____

Specialist _____ Phone _____

Symptoms and History of Migraines (include age of onset, aura or prodromal symptoms, if nausea or vomiting occurs, visual changes, etc.)

Medication Available at School for Treatment

Interventions:

1. Allow time to rest, preferably in a quiet, darkened room for 20 minutes after taking medication, if needed.
2. If medication isn't taken soon enough and symptoms aren't relieved, notify parents.

Restrictions/Precautions

I give permission for the information contained on this HCAP to be shared with adults in the school settings that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one school year or until the health status of physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

Health Care Provider (MD/DO/NP/PA)	Date	Parent/Guardian	Date	School Nurse	Date