GENEVA COMMUNITY UNIT SCHOOL DISTRICT #304
DEPARTMENT OF NURSING
MIGRAINE MANAGEMENT PLAN

CHILD NAME: _____ Grade: _____
School Year: _____
Effective date of plan: _____

According to your child's school health records, he/she has a history of migraine headaches. To allow us to better care for your child at school, please provide us with the following information. Return completed form to your child's school nurse's office.

I. CHILD'S HISTORY

A. Age of onset: _____

B. Frequency: _____

C. Presenting Symptoms: _____
_____

D. Triggers for migraines for your child?

	YES	NO
Stress	_____	_____
Exams	_____	_____
Exercise	_____	_____
Menstrual Cycle	_____	_____
Bright Lights	_____	_____
Medication	_____	_____
Specific foods (please list)	_____	
* Other (please be specific)	_____	

E. How long do they last? _____

F. Does the child have any warning (or aura) prior to one of these headaches? If so please describe: _____
_____
_____

G. Has a diagnostic work-up or testing been completed? If yes, please explain:
_____
_____

H. What helps to relieve the symptoms: _____
_____
_____

II. MEDICAL MANAGEMENT

A. Name of Medication Dosage Frequency Side Effects
1. _____
2. _____
3. _____

B. Additional Treatment: _____

C. Are medications needed at school? Yes_____ / No _____

If yes, please have a Medication Authorization Form signed by parent and physician and return the form to your child's school. Parent must bring meds to the school nurse.

III. EMERGENCY CONTACT INFORMATION:

Name Relationship to Child Phone Numbers

_____

_____

Physician Name_____ Phone Number_____

The migraine management plan may be shared with school staff to support your child's safety in school. Parents are encouraged to discuss their child's medical needs with the transportation department as well as sponsors/coaches working with your child before or after school hours.

Parent Signature _____ Date _____