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

CHILD NAME: _______________________ Grade: __________
School Year: _______________________ Date: __________

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. Once completed by you and your health care provider (MD, DO, APN, PA) please return to your child's school nurse's office.

I. HISTORY

A. Age of onset: _______________________
B. Frequency: _______________________
C. Presenting Symptoms: _______________________
D. Migraine triggers:

	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- maintenance or emergency Dosage Frequency
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 to the Nurse Office

Physician Name _______________________ Phone Number _______________

Physician Signature _______________________ Date _______________

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 _______________

(Rev. 2019)