WONEWOC-CENTER SCHOOLS MIGRAINE HEALTH PLAN

Student_____ **Date of Birth**_____
Grade_____ **Teacher**_____ **School Year**_____
Parent/Guardian_____ **Phone Number**_____
Practitioner_____ **Phone Number**_____

Headache Information
Diagnosis: _____ Describe aura (if any): _____ Triggers (if any): _____

GREEN ZONE – Prevent more headaches

Do or take this every day to help prevent YOUR headaches:

It may take 4-6 weeks to see a big change, so stick with it!
Visit headachereliefguide.com for more information about headaches and migraines.

~ Get enough sleep; keep a regular schedule

~ Eat healthy foods; don't skip meals

~ Drink enough water; avoid caffeine

~ Get regular exercise; manage your weight

~ Learn ways to relax; manage your stress

YELLOW ZONE – Don't wait. Act fast to treat your headaches

☐ Go to nurse office right away. Take your **quick-relief** medicine as soon as your headache starts:

Take: _____ Dose: _____
Route: _____ May repeat after _____ hours

Take: _____ Dose: _____
Route: _____ May repeat after _____ hours

Let your provider know if you need to take your quick relief medicines 3 or more days a week or if this plan isn't working.

~ Drink some water or sports drink if you can

~ Rest in a dark, quiet place for 30 minutes and practice relaxation exercises (deep breathing, guided imagery), if you can

~ You may need a different PE activity, dark glasses, or a quiet place to work for a while

RED ZONE – Time to get more help

Contact your **provider's office** if:
~ Your headache is much worse or lasting longer than usual
Go to the **Emergency Room** if:
~ You have new and/or very different symptoms like:

- Loss of vision
- Unable to move one side of face or body
- Trouble walking or talking
- Very confused or unable to respond

~ Call 9-1-1 if child loses consciousness or has stroke-like symptoms

Tools for school

Trigger Management	~ Allow student to keep a water bottle at desk ~ Allow student to use restroom when needed ~ May need to eat a mid-morning and/or mid-afternoon snack ~ May need access to a quiet place to eat lunch with a companion ~ May need an anti-glare screen filter or paper copies of assignments ~ Other: _____
Symptom Management	~ Allow student to go to nurse office as soon as headache or aura starts ~ Allow student to rest for 30 minutes before returning to class ~ Allow light-sensitive student to wear dark glasses as needed ~ Allow noise-sensitive student to work in a quiet place as needed ~ Allow a PE alternative (e.g. walking, stretching, yoga) as needed ~Other: _____

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PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication be administered by school personnel.
- I understand that medication may be given by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian.
- I will pick up unused medications at the end of the school year. Unclaimed medications will be discarded.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

_____ _____

Signature of Parent/Legal Guardian Date

PHYSICIAN ORDER:

The above medication(s) is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication may be given by non-medically trained school personnel. Please contact me if the following symptoms occur:

_____

_____ _____ _____

Physician Printed Name Address Phone

_____ _____

Signature of Physician Date