Migraines/ Headaches
Health Care Action Plan

Student Name_____

Teacher _____ Grade _____

Migraine Characteristics_____

Length _____

Severity _____

Migraine Triggers- check all that apply
___ Activities (explain) _____
___ Emotional factors, stress
___ Environmental factors (weather, perfume, altitude changes)
___ Foods and beverages (caffeine, processed foods, other)
___ Medications (over the counter and prescription)
___ Physical factors (hormonal changes, illness, fatigue)
___ Lack of sleep
___ Hunger

Medication/Dose/Frequency _____
Medication must be taken at the onset of symptoms
If your child will need medication at school, please go to the Kenston web site: www.kenstonlocal.org for the necessary medication forms.
Please bring the medication to school. DO NOT send with your child.

Plan of action for signs and symptoms of migraine:
1. Medication as directed
2. Allow to rest, preferably in quiet, darkened room for 20 minutes.
3. If symptoms are not relieved, notify parents.
4. Alternate plan of action _____

Contact Information: (Parent/Guardian):

1. Name _____ Phone _____

2. Name _____ Phone _____

Parent Signature _____ Date _____