Migraine Action Plan

Student Name: _____ Date of Birth____/____/____ Grade: _____

THE ABOVE STUDENT IS DIAGNOSED WITH MIGRAINES. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER MIGRAINES. PLEASE PLACE THIS FORM IN THE STUDENT'S MEDICAL FILE

Parent/Guardian Name: _____ Number where can be reached: (____) _____-_____

Student's Primary Care Provider: _____ Phone: (____) _____-_____

Migraine Characteristics: _____

_____

Daily Medication: _____

Dose: _____ Frequency: _____

Prevention Plan:

- ☐ Preferential seating
- ☐ Snacks throughout the day
- ☐ Water throughout the day
- ☐ Rest head on desk if needed
- ☐ Other: _____

Treatment Plan:

- ☐ Medication: _____
- ☐ Allow to rest in quiet, darkened room for 20 minutes.
- ☐ If symptoms are not relieved, notify parents.
- ☐ Other: _____

Trigger List:

- ☐ Stress
- ☐ Lack of sleep
- ☐ Hormones
- ☐ Hunger
- ☐ Caffeine
- ☐ Weather
- ☐ Chocolate
- ☐ Cheese
- ☐ MSG
- ☐ Artificial sweeteners
- ☐ Cured meats
- ☐ Dehydration
- ☐ Lights
- ☐ Strong odors, perfume, cleaning products
- ☐ Medication overuse
- ☐ Other:

_____

_____

_____ ____/____/____

Signature of Parent/Guardian Date

_____ ____/____/____

Signature of Physician Date