

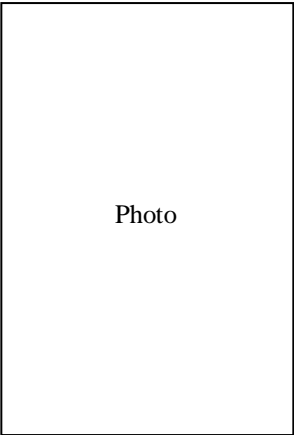
School Nursing Migraine Individualized Health Plan

<input type="checkbox"/>	Fennville Public Schools
<input type="checkbox"/>	Hamilton Public Schools
<input type="checkbox"/>	Holland Christian Schools
<input type="checkbox"/>	Holland Public Schools
<input type="checkbox"/>	West Ottawa Public Schools

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____ date of birth _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours. And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.

My child has been diagnosed with migraine headaches. The goal is to keep him/her in school and able to concentrate/participate in school activities.

Triggers: (parent to complete)

- | | | |
|--|--|--|
| <input type="checkbox"/> Missing a meal | <input type="checkbox"/> Sleep –oversleeping/lack of | <input type="checkbox"/> Lights/strobe or flashing |
| <input type="checkbox"/> Weather changes | <input type="checkbox"/> Stress | <input type="checkbox"/> Physical illness |
| <input type="checkbox"/> Exertion | <input type="checkbox"/> Various odors | <input type="checkbox"/> Loud/continuous noises |
| <input type="checkbox"/> Certain foods/drink(specify): _____ | | |

Other: _____

Migraine Symptoms

Treatment should begin with the first symptom for medication to be effective. Student should be allowed to rest for at least 20 minutes after medication.

Notify parent: at onset if no relief in 1 hour _____

MEDICATIONS TO BE GIVEN AT SCHOOL:

Name of Medication	Dosage	When To Use

MEDICATIONS GIVEN AT HOME:

Name of Medication	

Non-Pharmaceutical treatments:

<input type="checkbox"/> Water	<input type="checkbox"/> Rest
<input type="checkbox"/> Food	<input type="checkbox"/> Other _____

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____

Emergency Contact phone number: _____

PLEASE REVIEW PARENT PROVIDED INFORMATION, SIGN AND RETURN

Physician's name printed _____ Physician's signature _____

Physician's address: _____

Phone: _____ Fax: _____ Date: _____