Place Child's Photo Here

Katy Independent School District
Health Services Department

Migraine Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Students Name	Date of Birth	Grade
Parent Guardian	Phone	Cell
Parent Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Migraine Triggers:		
Daily Medications at home:		

Medication

Name	Dosage	Time	How Often	Route	Comments

1. Safe Zone:	1. Action:
Child has any of these: • No visible signs of pain • No additional warning signs • Denies pain/other symptoms • Can work/play	❑ Avoid triggers ❑ Allow desktop fluids and encourage fluid intake ❑ Allow extra bathroom breaks as needed

2. Caution Zone:	2. Action:
Child has any of these: • Complaints of head pain • Complaints of early migraine symptoms:_____ • Difficulty with work/play	❑ Administer _____ medication(s). ❑ Encourage student to drink fluids. ❑ Call parent if medicine is used more than _____ times in one week. ❑ Call doctor if medicine is used more than times in one week.

3. Danger Zone:	3. Action:
Child has any of these: • Medicine not helping. • Vomiting	❑ Use_____ medication. ❑ Notify parent. ❑ Notify doctor.

☐ I agree with the recommendations of my child's HCP and authorize Katy ISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate Katy ISD employees for the current school year.

Physician Signature	Printed Name	Phone	Date
Parent/Guardian Signature		Date	

NURSE USE ONLY: □ Transportation Notified □ IHP □ Added to Med Alert □ Other: _____