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)

Transportation
□ Car Rider □ Walker
□ Bus #_____
□ Other: _____

Student has permission to transport medication listed below to and from school?
□ YES □ NO

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 Signature:	Printed Name:	Phone:	Date:

ADDENDUM to Action Plan

NURSE USE ONLY:

☐ Transportation Notified: Date Faxed _____

☐ Bus Driver Notified

☐ Added to Medical Alerts

☐ Self-Carry

☐ Diet Modification: Date Faxed _____

☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◊ TRAINED STAFF MEMBERS ◊ (To be completed by campuspersonnel)	
Teacher's Name:	**Date:**
Teacher's Name:	**Date:**
Administrator's Name:	**Date:**
Office Staff's Name:	**Date:**
Cafeteria Staff's Name:	**Date:**
Bus Driver's Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**

OTHER COMMENTS:

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____