EAGLE COUNTY SCHOOLS

Eagle County School District
Individualized Health Plan
Migraine Health Care Plan

Effective date: _____

(Health Care Plans are good for one calendar year)

Picture

Student: _____ DOB: _____ Cell Phone: _____
Mother: _____ Work Phone: _____ Cell Phone: _____
Father: _____ Work Phone: _____ Cell Phone: _____
School: _____ Grade: _____ School Year: _____
Primary Physician: _____ Phone: _____ Fax: _____
Specialist: _____ Phone: _____ Fax: _____
Hospital of Choice: _____ Date of Diagnosis: _____
Medical Diagnosis: _____
Medications: _____ Allergies: _____
Triggers: _____

Migraines are a specific type of headache that is associated with vasodilatation and inflammation which causes the intense pain. Symptoms may include auditory, sensory, language, or motor disturbances. The headache may be associated with nausea and/or vomiting, light sensitivity, sound sensitivity. Resolution is often characterized by deep sleep and may cause fatigue up to 24 hours. Triggers that may precipitate a migraine may include stress, fasting, fatigue, exercise, and sleep deprivation, bright lights, head trauma, infection, menstruation, certain foods or chemicals, and contraceptives. Avoid triggers when possible.

GOAL/PLAN: To provide symptomatic treatment for headache and other symptoms.

If any/all of the following symptoms occur:

1. Headache
2. Nausea/vomiting
3. Vision changes
4. Other:_____

Then follow these guidelines:

1. Reduce environmental stimuli
2. Give the following medication:
   _____
   _____
3. Notify parents if symptoms continue or worsen
4. Encourage rest and relaxation
5. Reduce exposure to migraine triggers
6. Student takes the following preventative medication at home:
   _____
   _____

As parent/guardian of the student I give permission for this plan to be available for use in my child's school. The plan will be reviewed on a yearly basis or when there is a change in the student's condition. The Parent's signature indicates permission to contact the above mentioned health care provider(s) as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well-being while at school or during school related activities.

Physician: _____ Physician Signature_____ Date:_____

Parent: _____ Parent Signature _____ Date: _____

School Nurse: _____ Nurse Signature _____ Date: _____