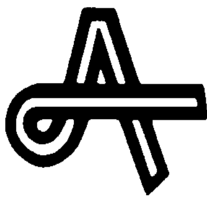

# calanes Union High School District

1212 Pleasant Hill Road • Lafayette, California 94549
925-935-2800 • Fax 925-932-2336

Student Photo Here

## MIGRAINE CARE PLAN

**Student's Name: _________________________________ Birth Date: ____________**
**Allergy To:__________________________________________________________**

This student has been diagnosed with Migraine and has medically prescribed interventions.
In addition, a Migraine Diary is attached to this form, which is helpful for the student to use upon symptoms of Migraine.

**SIGNS OF MIGRAINE MAY INCLUDE:**

- ☐ Moderate to severe pain intensity
- ☐ Visual disturbances
- ☐ Nausea/Vomiting
- ☐ Throbbing and/or disabling pain
- ☐ Photophobia (light sensitivity)
- ☐ Phonophobia (sound sensitivity)
- ☐ Neurological symptoms

**If student is experiencing these symptoms, please send student to School Nurse office with escort.**

1. Medication to be given at school:

| Medication | Dosage | Time given | Administration Route | Reason for medicine |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

2. **Allow student to rest in School Nurse's Office (dark, quiet conditions preferred) until symptoms improve sufficiently for student to return to class.**

3. **Call parent if student does not feel better and needs to go home.**

**To be completed by the Parent/Guardian:**
California Education Code Section 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. The parent/guardian is responsible for providing the medication, which should be sent in the original bottle and labeled with the student's name.
I request that medication be administered to my child in accordance with our authorized health care provider written instruction. I understand that designated non-medical personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible side effects.

**I agree with the above Migraine Care Plan: _______________________________ Date: ______**
Parent/Guardian Signature

**Authorizing MD SIGNATURE:**
**_____________________________________________Date:_________**
**MD Name, Address and Phone Number Stamp:**