

MIGRAINE INDIVIDUAL HEALTH PLAN

STUDENT NAME _____

MIGRAINE TRIGGERS _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: Yes No

Symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Mild, moderate or severe pain in the head | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Throbbing or pounding pain | <input type="checkbox"/> One-sided sensory changes, called an aura, which may include changes in vision, numbness or tingling |
| <input type="checkbox"/> Nausea and/or vomiting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sensitivity to light | |
| <input type="checkbox"/> Sensitivity to sound | |

Interventions:

1. Allow student to rest in a dark, quiet space.
2. Administer medication, if prescribed, at onset of symptoms
Medication: _____
3. Allow access to water and snack, as needed.
4. Call 911 if needed. Notify front office to direct EMS to student's location.
5. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.
6. Notify parents/guardians if needed, or designate another staff member to notify:
 - a. Parent/guardian name: _____ Phone number: _____
 - b. Emergency contact name: _____ Phone number: _____
7. Notify school nurse.

Additional information:
