BPS 101 Migraine Management Plan

Student Name: ____

Grade________

School Year : 2017-2018

According to your child's school health records, he/she has a history of migraine headaches. To allow us to better care for your child at school, please provide us with the following information. Return the completed form to the school health office.

I. STUDENT HISTORY

A. Age of Onset ____________________________

B. Frequency_______________________________

C. Presenting Systems:____

____

D. Triggers- do they occur with anything else?

	Yes	No
Stress	____	____
Exams	____	____
Exercise	____	____
Menstrual Cycle	____	____
Bright Light	____	____
Medication	____	____
Specific Foods	____	____
(please list)	_________________________________	
Other	____	____
(please list)	_________________________________	

E. How long do they last? _________________________

F. Does the student have any warning (or aura) prior to the onset of these headaches?

____

G. Has a diagnostic work up been completed? If yes, please explain:

____

____

H. What helps to relieve the symptoms? ____

____

II. MEDICAL MANAGEMENT

A. Medication(s): Please indicate frequency and dose:

____
____
____

B. Other Treatment: ____

C. Are medications required at school? Yes _____ No _______

(If so, attach the required BPS 101 medication administration form completed by your physician)

III. EMERGENCY CONTACT INFORMATION

Name:__________________________________Relationship to Student ___________________________

Phone Number ___________________________________

Physician:_____________________________________ Phone Number___________________________

Parent/Guardian Signature:_________________________________ Date:_________________________