Effective date:

Headache/Migraine

Individualized Healthcare Plan for School

Student's Name:_____ Birth Date:_____

Parent:_____ Phone:_____ Email:_____

PART ONE: To be completed by PARENT

Has your child been diagnosed with migraine headaches? ▣Yes □No

How often does your child have headaches?_____

Does your child see a healthcare provider for headaches? ▣Yes □No If yes, name of provider:_____

Anything else you would like the school to know about your child's headaches (triggers, prevention, etc):

_____

_____

_____

Does your child need medications or any special accommodations at school?

□ Yes (healthcare provider completes the next section and a med authorization if needed and return to school nurse)
□ No (sign below and return to the school nurse)

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this plan and communicate with healthcare provider if needed. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. I will update the school nurse if my child's situation changes.

Parent signature:_____ Date:_____

PART TWO: To be completed by HEALTHCARE PROVIDER

Accommodations needed at school:

_____

_____

_____

_____

_____

Health care provider signature:_____ Date:_____

PART THREE: To be completed by SCHOOL NURSE

504 needed? □Yes □No Accommodations:

Signature:

Review Date	School	Grade	Notes:	Nurse Signature: