ST JOHNS CLASSICAL ACADEMY
SCHOOL HEALTH SERVICES
SCHOOL YEAR _____

HEADACHE/MIGRAINE MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

(Must be filled out completely by Physician/Healthcare Provider) This document serves as both the Headache/ Migraine Medical Management Plan and Emergency Action Plan if completed by the Healthcare Provider.

Scholar Name: _____ DOB: _____ Grade: _____ Allergy: _____
Parent / Guardian: _____ Phone: _____ Phone: _____
Physician / Provider: _____ Phone: _____ Office: _____
Aura Type: _____ Length: _____ Description: _____

Triggers: ☐ Stress ☐ Anxiety ☐ Exertion ☐ Missing a Meal ☐ Cold/Flu ☐ Weather ☐ Exertion
☐ Odors ☐ Dehydration ☐ Sinus Issues ☐ Lack of Physical Activity ☐ Food/Drinks: _____
☐ Loud/Continuous Noises ☐ Lack of Physical Activity ☐ Lights/strobe or flashing ☐ Sleep – oversleeping/lack of
☐ Other: _____

Actions to Prevent Headaches:

Do this every day to help prevent YOUR headache:
☐ _____
☐ _____
☐ _____
☐ _____

- Get enough sleep; keep a regular schedule
- Eat healthy foods; do not skip meals
- Drink enough water; avoid caffeine
- Get regular exercise; manage your weight
- Learn ways to relax; manage your stress

Medications: Healthcare Providers please write a COMPLETE medication order. Medication and other equipment to be supplied by the parent to the school. Medications MUST GO WITH THE SCHOLAR if he/she is off school grounds (i.e. band or field trips, sporting events, etc.)

Name of Medication:	**Name of Medication:**	**Act Fast to Treat Your Headache:**
• Dose:	• Dose:	• Drink water or sports drink
• Route:	• Route:	• Rest in dark place for 30 minutes
• May repeat after: hours.	• May repeat after: hours.	• Practice relaxation exercises
• Other:	• Other:	○ Deep breathing
Location of Medication:	**Location of Medication:**	○ Guided imagery
☐ School in Health Room	☐ School Nurse in Health Room	• Try using dark glasses
☐ Carried by Scholar	☐ Carried by Scholar	• Find a quiet place to work
☐ Kept with Teacher/Staff	☐ Kept with Teacher/Staff	• May need some noise reducing alternative devices
Scholar may carry and/or self-administer:	**Scholar may carry and/or self-administer:**	• Try just closing your eye for a awhile
☐ Yes ☐ No	☐ Yes ☐ No	

Management of Severe Headache/Migraine:

Contact Parent if:
- Headache does not respond to treatment within 1 hour
- Headaches have a sudden change in characteristics for features
- Headaches seem to be increasing in frequency

Contact Provider's Office if:
- Headache is much worse after medication or lasting longer than usual
- **If you have to repeat the medication**

Go to the Emergency Room / Call 9 1 1 if:
- You have a new and/or very different symptom(s) like:
  - loss of vision
  - unable to move one side of your face/body
  - very confused
  - unable to respond
- Notify School Nurse if 911 called @ Ext: _____
- Notify Admin if 911 called @ Ext: _____

Physician Signature (Required) **Date**

Parent Signature (Required) **Date**

Nurse Signature (Required) **Date**

OFFICE STAMP

Copies Given To:

☐ Parent ☐ Teacher ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th
☐ PE ☐ Cafeteria ☐ Spanish ☐ Latin ☐ Music ☐ Art ☐ Coach ☐ ESE ☐ 8-12 th
☐ Other