Scurry-Rosser Migraine Action Plan

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ Date of Birth: _____

Grade: _____ School Year: _____ Homeroom Teacher: _____

Migraine Triggers: _____

Daily Medications: _____

1. Safe Zone:	**1. Action:**
Child has any of these: • No visible signs of pain • No additional warning signs • Denies pain/other symptoms • Can work/play	☐ Avoid triggers ☐ Allow desktop fluids and encourage fluid intake ☐ Allow extra bathroom breaks as needed _____

2. Caution Zone:	**2. Action:**
Child has any of these: _____ • Complaints of head pain • Complaints of early migraine symptoms: • Difficulty with work/play	☐ Administer _____ medication(s). ☐ Encourage student to drink oz of water or sports drink. ☐ Call parent if medicine is used more than _____ times in one week. ☐ Call doctor if medicine is used more than _____times in one week.

3. Danger Zone:	**3. Action:**
Child has any of these: • Medicine not helping. • Vomiting	☐ Use _____medication. ☐ Notify parent. ☐ Notify doctor.

HealthCare Provider: _____ Phone#_____
(Please Print) Fax#_____
Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

Home Phone#_____ Work Phone#_____ Cell Phone#_____