DIXON MONTESSORI CHARTER SCHOOL
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2019/2020 School Year

Migraine Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ D.O.B.: _____ Grade:_____

Migraine Triggers: _____

Daily Medication(s):_____

Nonmedical interventions:_____

1. Safe Zone:	Action:
Child has any of these symptoms: • 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:	Action:
Child had any of these symptoms: • Complaints of head pain • Complaints of early migraine symptoms:_____ • Difficulty with work/play	• Administer_____ • 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:	Action:
Child has any of these symptoms: • Medicine not helping • Vomiting	• Use _____ medication • Notify Parent • Notify Doctor

HealthCare Provider: _____ Phone Number:_____
(Please Print) Fax:_____
HealthCare Provider Signature:_____ Date: _____
Parent/Guardian Signature:_____ Date:_____
Home Phone:_____ Work Phone: _____ Cell Phone: _____