CHRONIC HEADACHE/MIGRAINE ACTION PLAN

Student:_____ D.O.B._____

Grade:_____ Teacher:_____

EMERGENCY INFORMATION:

Parents'/Guardians' Names:_____

Physician's Name:_____ Telephone_____

Headache/Migraine medication and dose

_____

Other medications that student is taking_____

Migraine triggers -check all that apply:
____Activities_____(explain)
____Emotional factors, stress
____Environmental factors (weather, altitude changes)
____Foods and beverages (caffeine, processed foods, other)
____Medications (over-the-counter and prescription)
____Migraine characteristics: length_____, severity_____
____Physical factors (hormonal changes, illness, fatigue)
____Lack of sleep
____Perfume
____Hunger

Plan of action for signs/symptoms of migraine:

1._____

2._____

3._____

Parent/Guardian
Signature:_____Date:_____

Physician
Signature:_____Date:_____