OCONOMOWOC
AREA SCHOOL DISTRICT
EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

Migraine
Health Care Plan

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name ______________________ School Year ______________
Birthdate ______________________ School ______________
Practitioner ______________________ Grade ______________
Practitioner Phone ______________________ Practitioner Fax ______________

☐ **Migraine symptoms are no longer an issue for my child. (Please sign and return Care Plan)**

The above student has been diagnosed with migraine headaches. Migraines in this child are often identified by the following characteristics:

______Moderate to severe pain intensity
______Throbbing pain
______Disabling pain
______Nausea and/or vomiting
______Photophobia
______Phonophobia

This child has been prescribed: *Give medication(s) at onset of migraine, without delay.*

Medication	Dosage	Time(s)	Route	Taken at Home or School
#1				
#2				
#3				

Potential side effects to watch for include: ____

If needed, please allow the child to rest for____________________. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

Please notify the parent if:

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency

Other notes:____

*******Please supply the school with the needed medication(s) on or prior to the first day of school******

⇨ How should medications be returned home at the end of the year? ☐Sent home with Student ☐Parent/Guardian Pick-Up

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named physician (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

⇨ ____

Parent/Guardian Signature **Date**

FOR INHALED MEDICATIONS

⇨ ☐ I have instructed this student in the proper way to use his/her medications. It is my professional opinion that he/she **should** be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that this student **should not** carry his/her medication by him/herself.

⇨ ____

Practitioner Signature **Date**