Migraine/Headache Care Plan

Dear Parents/Guardians,

This packet includes a Migraine/Headache Care Plan and Permission to Administer Medication form. These completed forms will assist The Classical Academy staff in knowing how to manage your student's condition should an emergency arise.

The Permission to Administer Medication form is your physician's order for the school to administer a medication. Academy District Twenty and The Classical Academy policies require the signature of a health care provider with prescriptive authority, as well as the parent/guardian signature, for all medications to be given at school. This includes prescription and over-the-counter medications such as cough drops, Tylenol etc. Each medication requires a separate Permission to Administer Medication form. The forms are available on our website at http://www.tcatitans.org. High School students may carry and self-administer their own medications with the exception of controlled substances, which must be kept in the health room with a completed medication form.

Please fill in the parent portion of the care plan and medication form prior to giving to your physician for completion and signature. Submit all forms to your student's health room before the start of school. **Please be sure to complete all pages of this packet as we will not accept incomplete Care Plans or medications without Permission to Administer Medication form.**

If you have questions, please feel free to contact the school nurse at your student's campus.

Sincerely

Your Health Services Team

Academy School District #20/TCA
Migraine/Headache Health Care Plan

Name: **Effective Date:**
Parent: **School:**
Doctor: **School Nurse:**
Neurologist:
Special Ed: __ 504 __ **DOB:**

Medications taken at home: _____

Medications taken as needed at school or home: _____

_____

Headaches symptoms account for many visits to the health room and phone calls to parents. While many headaches may be painful, often they do not constitute a serious problem. Tension headaches, characterized by scalp or neck pain or a feeling of a "tight band" around the head, are often caused by stress or poor posture. The "classic" migraine headache is characterized by an aura (warning of an impending migraine), such as numbness of the face or arm, tingling sensations, or visual changes. Following the aura, pain frequently occurs on one side of the head. Light sensitivity may worsen the headache. The cause of migraines is not exactly known but appears to involve chemical changes that make the blood vessels in the brain constrict and dilate. Triggers may include stress, fatigue, overwork, menstruation, and dietary intake (caffeinated drinks, chocolate, or cheese).

Triggers: _____

Symptoms: _____

_____

Problem: Pain
Goal: Relieve discomfort.
Action:

1. Administer medication, as prescribed:
    a. Medication, if given during the aura, may prevent or decrease the pain.
    b. Side effects that must be reported to the school nurse and parents include:
    _____.
2. Allow student to rest in the health room for at least 20 minutes.
    a. If there is no improvement or if the headache worsens, then student will take 2nd medication, if available.
    b. Parent will be contacted.
3. Document headache symptoms, length of symptoms, time symptoms began, any precipitating factors, and actions taken.

_____ _____
Physician Signature Parent Signature

_____
School Nurse Signature

** This Health Plan and any nurse delegation related to this plan are for use during normal operational school hours. After hours: call parent(s) and/or 911 for all medical concerns/emergencies. **

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Complete ONE form for EACH prescription or over-the-counter (OTC) medication

Student Name: _____ Date of Birth: ___ / ___ / ___

Medication Name, Form, and Strength (i.e., Children's Tylenol, liquid, 160mg/5ml): _____

_____

Reason for Medication: _____

Total Dose to Administer: _____ Route: _____ Time: _____

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: ___ / ___ / ___ End Date: ___ / ___ / ___

Parent/guardian provided FDA-approved over-the-counter (OTC) medications may be administered at the school nurse's discretion without a signature from a prescribing provider below if given strictly within manufacturer's recommendations and instructions. All prescription medications must have a prescribing provider's signature.

Name of Health Care Provider: _____

Office Phone Number: _____ Fax Number: _____

Signature of Health Care Provider with prescriptive authority:

_____ Date: ___/ ___/ ___

I understand that whenever possible, medication should be administered at home. I also understand that it is my responsibility to furnish the medication to school in the original pharmacy-labeled container or over-the-counter container identified with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian: _____ Date: ___ / ___ / ___

Contact phone numbers (home, cell, other): _____

Parent/Guardian Signature: _____