MIGRAINE ACTION PLAN

Student:_____D.O.B._____
Grade:_____Teacher:_____

EMERGENCY INFORMATION:
Parents'/Guardians' Names:_____
Mother: Telephone(H)_____(W)_____
Father: Telephone(H)_____(W)_____
Physician's Name:_____Telephone_____

In case of emergency, contact:
1._____
2._____
3._____

Migraine medication and dose _____
Other medications that student is taking_____

Migraine triggers - <u>check all that apply:</u>
____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

<u>Plan of action for signs/symptoms of migraine:</u>

1._____
2._____
3._____

Parent/Guardian Signature:_____

Revised 5/08 P. Rok