

School Nurse Instruction Form

Date Instructions Provided: _____

Physician Name: _____

Physician Contact information: _____

Name of Child: _____

The child _____ has been diagnosed with migraine headaches. Migraine in this child is often identified by the following characteristics:

_____ Moderate to severe pain intensity

_____ Throbbing pain

_____ Photophobia

_____ Phonophobia

_____ Disabling pain

_____ Nausea and/or vomiting

The child _____ has been prescribed:

Name of medication #1 to be given _____

Dose of medication #1 to be given _____

Name of medication #2 to be given _____

Dose of medication #2 to be given _____

This medication should be given as soon as the child recognizes the onset of a migraine, without delay.

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
- You are running low on medication prescribed for this child
- You have any other concerns