St. Theresa School Headache Action Plan (2018-2019)

H

Name (Last) _____ (First) _____ Room _____

Date of Birth _____ Allergies _____

Parent /Guardian _____ Mother Phone _____

Parent/Guardian _____ Father Phone _____

Diagnosed when _____Hospitalizations _____

Description of a typical Headache/Migraine _____

Other chronic / current concerns: _____

Possible Triggers _____

Average Length of Time the headache lasts _____

All Current medications and any additional information_____

Medication	Dosage	Time	Side effects

Other necessary information

_____

_____

Emergency Treatment Plan:

Notify (i.e. Parents or Grandparents, etc.)

Give Medication per MD order

Rest and return to class or called to taken home

Parent's signature_____ Date _____