

**EMERGENCY PROCEDURE INFORMATION
MIGRAINES**

To the parent(s)/guardian(s) of: _____ Date _____

You have indicated on the Emergency Procedure Card that your child has migraine headaches. In order for school personnel to respond to this effectively, additional information would be helpful. Please answer the following:

1. Is your child under a doctor's care for this condition? Yes___ No___
Physician_____ Phone_____

2. Does your child take medication for this condition? Yes___ No___
Please specify medication_____ Dosage_____

3. Has your child been hospitalized for a migraine headache? Date_____

4. Date of your child's last migraine_____

5. Please list specific triggers for your child's migraine headaches:

6. Does your child experience an aura before a migraine headache?
If so, please describe the aura:

7. Will medication be kept at school? Yes___ No___
If so, please accurately complete the enclosed medication consent form. Prescription medications require a doctor's order. **Medication will be supplied by parent/guardian.**

8. Please circle the number(s) indicating how you would like school personnel to respond should the need arise:
1. Administer medication as prescribed
2. Allow child to rest for 30 minutes
3. Call parent/guardian
4. Other, please specify_____

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This information will be shared with those with a need to know.

Parent/Guardian Signature_____Date_____

