Headache Health Plan

Student Name:	Graduation Year:
Parent/ Guardian Name(s):	Phone Number(s):

Headache Symptoms		
_____ Moderate to Severe Pain Intensity _____ Nausea / Vomiting _____ Throbbing Pain _____ Visual Disturbances	_____ Light Sensitivity _____ Noise Sensitivity _____ Aura (please list aura symptoms):	_____ Other (please list):

Treatment Plan

1) Call the school nurse (South Campus x4108 / North Campus x4208)
2) Administer medications listed below that are ordered by the physician.
3) Allow student to rest for 30 minutes in health room or dark room, and drink fluids. Then have student return to class.
4) Student will be allowed to wear sunglasses in class, and take breaks from electronic screens.
5) Student will be allowed to drink and/or eat a snack in class.
6) If headaches are increasing in frequency, not resolving with interventions, or have a sudden change in characteristics, call parents.

Parent/ Guardian Medication Consent

1) I, hereby, give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my student according to the directions listed by the physician below should my student need assistance.
2) I, hereby, give the school nurse permission to contact the student's physician to discuss this action plan.
3) I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
4) I agree to provide written notification to the school nurse at the termination of this request or when any changes are made in this care plan and/or medication.
5) I will provide any medications needed by my student in its original pharmacy packaging.
6) I understand that this care plan is valid for only the school year it is provided in. I will obtain a new physician order prior to the start of a new school year.

Parent/ Guardian Signature:	Date:

Physician Medication Orders

Name of Medication	Dose / Frequency	When to Administer	Side Effects

Physician Authorization

Physician Name:	Physician Signature:	Phone Number:	Date: