**BPS 101 Migraine Management Plan**

**Student Name: _____**

**Grade_____**

**School Year : 2019-2020**

**According to your child's school health records, he/she has a history of migraine headaches. To allow us to better care for your child at school, please provide us with the following information. Return the completed form to the school health office.**

**I. STUDENT HISTORY**

**A. Age of Onset _____**

**B. Frequency_____**

**C. Presenting Systems:_____**

**_____**

**D. Triggers- do they occur with anything else?**

| | Yes | No |
|---|---|---|
| **Stress** | **____** | **____** |
| **Exams** | **____** | **____** |
| **Exercise** | **____** | **____** |
| **Menstrual Cycle** | **____** | **____** |
| **Bright Light** | **____** | **____** |
| **Medication** | **____** | **____** |
| **Specific Foods** | **____** | **____** |
| **(please list)** | **_____** | |
| **Other** | **____** | **____** |
| **(please list)** | **_____** | |

**E. How long do they last? _____**

**F. Does the student have any warning (or aura) prior to the onset of these headaches?**

**_____**

**G. Has a diagnostic work up been completed? If yes, please explain:**

_____

_____

**H. What helps to relieve the symptoms? _____**

_____

**II. MEDICAL MANAGEMENT**

**A. Medication(s): Please indicate frequency and dose:**

_____

_____

_____

**B. Other Treatment: _____**

**C. Are medications required at school? Yes _____ No _____**

**(If so, attach the required BPS 101 medication administration form completed by your physician)**

**III. EMERGENCY CONTACT INFORMATION**

**Name:_____Relationship to Student _____**

**Phone Number _____**

**Physician:_____ Phone Number_____**

**Parent/Guardian Signature:_____ Date:_____**