Portage Community School District

Headache Management Plan

Student Name:	DOB:
	Grade/School
Parent/Guardian Name:	Phone #:
Parent/Guardian Name:	Phone #:
Other Emergency Contact aware of child's condition:	Phone #:
Physician Name:	Phone #:

Signs/Symptoms to watch for:
Aura __
Headache ___
Nausea ___
Vomiting ___
Sensitivity to light ___
Sensitivity to noise ___

Intervention:
Drink water ____
Rest 20 minutes (in dark room if possible) ____
Bland snack like saltine crackers ____
Cold or ice pack ____
Wet paper towel over eyes – warm/cold
Put on glasses ____

Name of medication: _____
See completed **Medication Request / Procedure Form**
Side effects of med that you expect: _____

_____

Known triggers: Exposure to strong odors, exposure to cigarette or vape/e-cig vapors, flashing light, hormone changes, caffeine intake or lack of, weather changes, consumption of processed food, seasonal allergies, altered sleep patterns, use of screens (circle those that apply)

Medication will be kept in the office* and a **Medication Request / Procedure Form** is completed and on file.

Next Steps: If the interventions above do not begin to resolve the headaches, please do the following:

_____

Parent Signature: Date:

School Nurse Signature: Date:

***Medication storage location will be indicated on the Medication Request / Procedure Form.

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