Wonewoc-Center School District

Home of the Wolves

101 School Road, Wonewoc, WI 53968

JODI WELDY
SCHOOL NURSE

PHONE: (608) 464-3165 ext. 131
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MIGRAINES HEALTH PLAN

Student_____ **Date of Birth**_____
Grade_____ **Teacher**_____ **School Year**_____
Parent/Guardian_____ **Phone Number**_____
Practitioner_____ **Phone Number**_____

☐ **Migraine symptoms are no longer an issue for my child. (Please sign and return Health Plan)**

The above student has been diagnosed with migraine headaches. Migraines in this child are often identified by the following characteristics:

_____Moderate to severe pain intensity
_____Throbbing pain
_____Disabling pain
_____Nausea and/or vomiting
_____Photophobia
_____Phonophobia

This child has been prescribed: ***Give medication(s) at onset of migraine, without delay.***

Medication	Dosage	Time(s)	Route	Taken at Home or School
#1				
#2				
#3				

Potential side effects to watch for include: _____

If needed, please allow the child to rest for_____. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

Please notify the parent if:

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency

Other notes: _____

******Please supply the school with the needed medication(s) and medication consent form(s) on or prior to the first day of school******

Continued on back

Please remember that all medications need to be picked up by Parent/Guardian at the end of the year. Unclaimed medication will be discarded.

- I hereby give permission to WC's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Wonewoc-Center School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

Parent/Guardian Signature: _____Date:_____

Reviewed By (School Nurse): _____Date: _____