## Wonewoc-Center School District

## Home of the Wolves 101 School Road, Wonewoc, WI 53968

JODI WELDY SCHOOL NURSE PHONE: (608) 464-3165 ext. 131 FAX: (608) 464-3325

## **MIGRAINES HEALTH PLAN**

Student			Date of Birth			
Parent/Guardian						
Practitioner						
Migraine symptoms are no	longer an issue for	my child. (Please sign	and return Healt	h Plan)		
The above student has been dia characteristics:	gnosed with migrain	ne headaches. Migraine	s in this child are	often identified by the following		
Moderate to severe pain intensity			Nausea and/or vomiting			
Throbbing pain			Photophobia			
Disabling pain		Pho	onophobia			
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 fo	r include:		•			
If needed, please allow the child	to rest for	After th	is time, the child m	nay return to the classroom if pain		
relief is achieved or if the child f	eels they can contin	ue to function.				
Please notify the parent if:						
Headache does not resp	ond to given treatm	ent within 2 hours				
<ul> <li>Headaches have a sudd</li> </ul>						
Headaches seem to be	increasing in frequer	ncy				
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\*\*\*

## 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:
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Reviewed By (School Nurse):	Date: