Information for School Nurse

My child, _____, has been diagnosed with migraine disease. During a migraine attack, my child may experience:

- ☐ moderate to severe head pain
- ☐ nausea and/or vomiting
- ☐ sensitivity to light
- ☐ sensitivity to sound
- ☐ visual distortions
- ☐ dizziness
- ☐ aphasia
- ☐ nausea and/or vomiting
- ☐ mood changes
- ☐ tiredness/sleepiness
- ☐ other: _____

When my child experiences a migraine attack, it is important that he/she take medication as soon as possible. The following medication(s) have been prescribed by my child's physician to be taken when he/she has a migraine attack:

Name of medication: _____

Dosage/directions: _____

Name of medication: _____

Dosage/directions: _____

Potential side effects to watch for: _____

Please contact parent if...

- my child reports symptoms that are unusual for him/her or are extreme.
- my child's medication does not provide relief within two hours.
- my child's migraines seem to be increasing in frequency or severity.
- you need more of my child's medications.
- you wish to discuss anything related to my child's health.

To verify this information for you, my child's physician has also signed below. Thank you!

_____ _____
Parent's Signature Date

_____ _____
Parent's Name (Printed) Phone Number

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (Printed) Phone Number