SOUTHERN WILL COUNTY COOPERATIVE for SPECIAL EDUCATION

ADMINISTRATIVE DISTRICT: TROY 30C

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Executive Director

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GRACE DOYLE
Assistant Director

MIGRAINE ACTION PLAN

Student Name: _____ Date of Birth: _____

Grade: _____ School Year: _____ Program: _____

Migraine Triggers: _____

Daily Medication: _____

1. SAFE ZONE:	1. ACTION:
Student has any of these: • No visible signs of pain • No additional warning signs • Denies pain/other symptoms • Can work/play	• Avoid triggers • Allow desktop fluids and encourage fluid intake • Allow extra bathroom breaks as needed

2. CAUTION ZONE:	2. ACTION
Student has any of these: • Complaints of head pain • Complaints of early migraine symptoms:_____ _____ • Difficulty with work or play	• Administer _____ medications • Encourage student to drink _____oz of water or sports drink • Call parent if medicine is used more than _____ times in one week. • Call doctor if medicine is used more than _____ times in one week

3. DANGER ZONE:	3. ACTION:
Student has any of these symptoms: • Medicine not helping • Vomiting	• Administer _____ medications • Notify parent • Notify doctor

Healthcare Provider: *(Print)*_____ Phone: _____

Fax: _____

Provider Signature: _____ Date:_____

Parent Signature: _____ Phone: _____ Date: _____